

# **County of San Diego Health & Human Services Agency**



## **Children's Mental Health Services Tenth Annual Report Fiscal Year 2007-2008**



## **County of San Diego Board of Supervisors**

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Report prepared by the

**Child and Adolescent Services Research Center (CASRC)**

## **Acknowledgements**

Our sincere appreciation to the youth, families, and staff who gave their time to complete the evaluations and surveys necessary to produce this report.

# Key Findings

The following are the key findings from the Children's Mental Health Services System in Fiscal Year 2007 – 2008.

1. The number of clients receiving services through the Children's Mental Health System has increased over the past 2 years, with **over 17,600 youth<sup>1</sup> receiving services in FY07-08.**
2. **Over 50% of Children's Mental Health Services clients are Hispanic.** San Diego County has served an increasing proportion of Hispanic clients over the past 5 years, moving from 45% of clients in FY03-04 to 51% of clients in FY07-08.
3. **Over 60% of Children's Mental Health Services clients are male.** This has been consistent over the past 5 years.
4. The **four most common diagnoses** in the Children's Mental Health System are Oppositional defiant disorders, adjustment disorders, depressive disorders, and ADHD.
  - There are **significant differences in the distribution of diagnoses by racial/ethnic groups**, with a large difference seen in the Bipolar disorders: almost 50% of youth diagnosed with Bipolar disorder are White, although White clients compose less than 30% of the total CMHS population.
5. **Over 35% of Children's Mental Health Services clients also received Special Education services** during the fiscal year.
6. **Over 37% of youth clients, ages 13 and older, reported that they did not live with their parents at some point during the last 6 months.** Over 10% reporting having been in foster care, while almost 15% had lived in a group home.

<sup>1</sup> "Youth" refers to all children and adolescents (ages 0-17) and young adults (ages 18-25) who received mental health services through CMHS providers in FY07-08.

## Key Findings

7. **Use of Inpatient services has steadily dropped over the past 4 years**, from 4.3% of Children's Mental Health Services clients utilizing inpatient services in FY04-05 to 2.8% of clients using inpatient services in FY07-08.
8. **15% of Inpatient clients were re-admitted to inpatient services within 30 days of discharge**
  - 27% of Inpatient clients did not receive any Children's Mental Health services in the 30 day period after discharge from the inpatient setting.
9. 848 clients (4.8%) used Emergency Screening unit (ESU) services in FY07-08
  - **For 216 clients (25.5% of the ESU sample), ESU services were the only Children's Mental Health services received during the fiscal year.**
10. Based on input from youth and caregivers, **youth experienced significant improvements between Intake and Discharge**, as measured by the Child and Adolescent Measurement System (decrease on the internalizing, externalizing, and total problems scales and increased on the social competence scales).
11. **Youth and Parents in San Diego County report higher levels of satisfaction** with their child's mental health services on the Youth Services Survey (YSS) than youth and families in the Southern California region or California as a whole, a pattern that has been present for the past three years.
12. Results from the YSS show significantly different levels of satisfaction by the **service type** received by the youth.
  - **Youth receiving day treatment services reported lower levels of satisfaction** in all seven YSS domains, as compared to the other service groups.

# Introduction to CMHS

San Diego County Children's Mental Health Services (CMHS) primarily serves children and adolescents ranging in age from 0-17 years old, with some programs serving young adults, 18 to 25 years old, who are transitioning to adult services. San Diego is the second largest county in California, with a youth population estimated at approximately 780,977 in 2008 and a vast diversity of race/ethnic groups, cultures and spoken languages. In FY07-08, CMHS provided mental health services to over 17,600 youth.

In Fiscal Year 2007-2008, the CMHS program served youth with mental health needs through three provider systems: Organizational Providers, Fee-for-Service Providers, and Juvenile Forensic Providers.

- **Organizational providers** are community-based agencies and county-operated sites that are either part of the Health & Human Services Agency (HHS) or have contracts with HHS to provide mental health treatment services. These organizational providers are diverse and distributed across the county. They can be general treatment clinics, or they can provide services to a specialized population or a population in a specific setting (e.g. school, home). Services are being delivered in 321 schools in the county. The county's Quality Improvement (QI) unit monitors these multiple providers and the clinical services provided to youth.
- **Fee-for-service providers** are primarily licensed **clinicians in private practice** who provide services to clients on a fee-for-service basis. These providers are spread out over the county and represent a diversity of disciplines, cultural-linguistic groups and genders in order to provide choice for eligible clients. There are also three fee-for-service **inpatient hospitals** that provide services for child and adolescent clients in San Diego County.
- **Juvenile Forensic Services** provide services to youth involved in Child Welfare and/or Probation services. Juvenile Forensic Services provides assessment, crisis intervention, consultation, individual therapy, and treatment services to children and adolescents who are involved with the Juvenile Court as either dependents or delinquents. Services are provided throughout the County at sites including Juvenile Hall, Girl's Rehabilitation Facility, Polinsky Children's Center, Juvenile Ranch Facilities, and Camp Barrett. Some of the services are provided by contract agencies, such as intensive case management and outpatient services, transition services for wards leaving Juvenile Hall, and parent peer support counseling for families of children in Juvenile Hall.

CMHS delivered services through 103 different programs in FY2007-2008, including:

- 58 Outpatient programs,
- 32 Day Treatment programs,
- 7 Case Management programs, and
- 6 Inpatient and Emergency Services providers



# Introduction to CMHS

San Diego County CMHS operates as a System of Care (SOC) program. **The System of Care is a comprehensive, integrated, community based, clinically sound and family centered structure for delivery of mental health and related supportive services to the children of San Diego County.** The System of Care takes a broad approach, breaking down the separations that occur between and among traditionally structured and funded services and programs. It evolved over time through the collaboration of its stakeholders: families and youth receiving services, public sector agencies (Children's Mental Health, Child Welfare, Juvenile Justice, Alcohol and Drug Services), private providers and agencies, and Education. Through this collaborative effort, school based mental health services have been established in 34 schools districts, bringing service availability to children in 321 schools throughout the County. The multi-sector Children's System of Care Council meets on a monthly basis to advise the CMHS Director and provide community oversight for the System of Care.

## Children's Mental Health Services and the Mental Health Services Act (MHSA)

Recently, Children's Mental Health Services received a welcome boost from the Mental Health Services Act (MHSA) which provides much needed funding to fill services gaps and to provide community based services targeted toward populations who are un-served or underserved. Through a process of community collaboration, a Community Services and Support Plan was developed to provide services that are client/family driven, wellness focused, culturally competent, and more completely integrated with companion services. Thirty new programs began in FY06-07 and FY07-08 to serve children and youth, transition age youth, adults, and older adults. New services fall into three general areas:

- **Outreach and Engagement Services:** Services to reach out to people who may need services but had not been receiving them. Examples include Chaldean outpatient services, early childhood mental health services, and services for the deaf and hard of hearing.
- **System Development Services:** Services which improve the scope and availability of mental health services and supports for consumers currently receiving mental health services. Examples include Family Education services, mental health and primary care coordination through community clinics, and enhanced outpatient mental health services for transition ages youth.
- **Full Service Partnerships:** Comprehensive programs which provide all necessary services and supports, including intensive services, to clients with a high level of need to enable them to live in their community. Examples include the Cultural Access and Resource Enhancement program, wraparound services for youth involved in Child Welfare, and the Counseling Cove services for homeless youth.

## Purpose of This Report

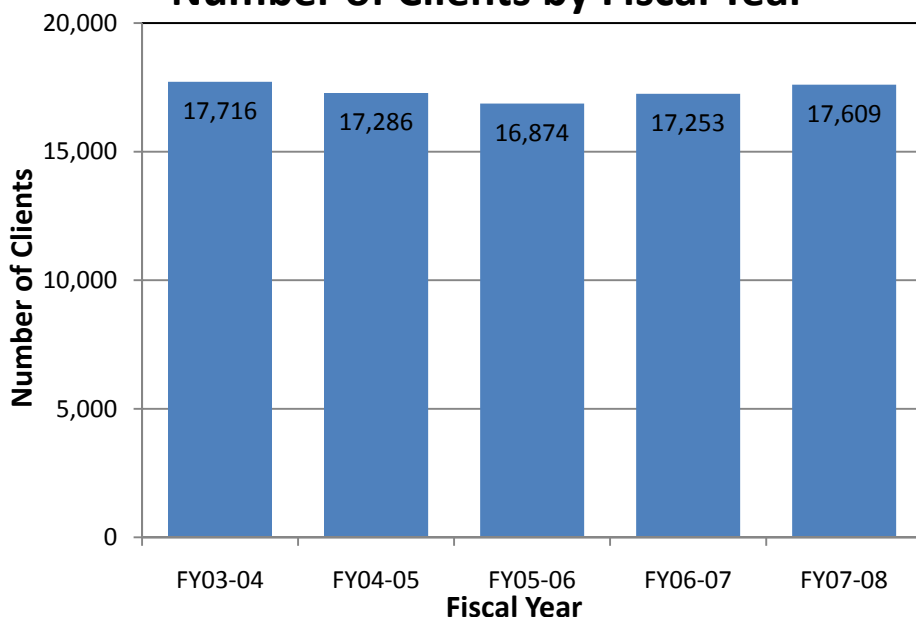
This report provides a snapshot of the Children's Mental Health System in Fiscal Year 2007-2008. It describes the population being served and shows trends in how the population has changed over time. It also describes the types of services received through the Children's Mental Health System, and provides information on client outcomes and satisfaction. The body of the report focuses on a graphical presentation of the information, while the appendices provide information in more detail.

# Youth Receiving Mental Health Services

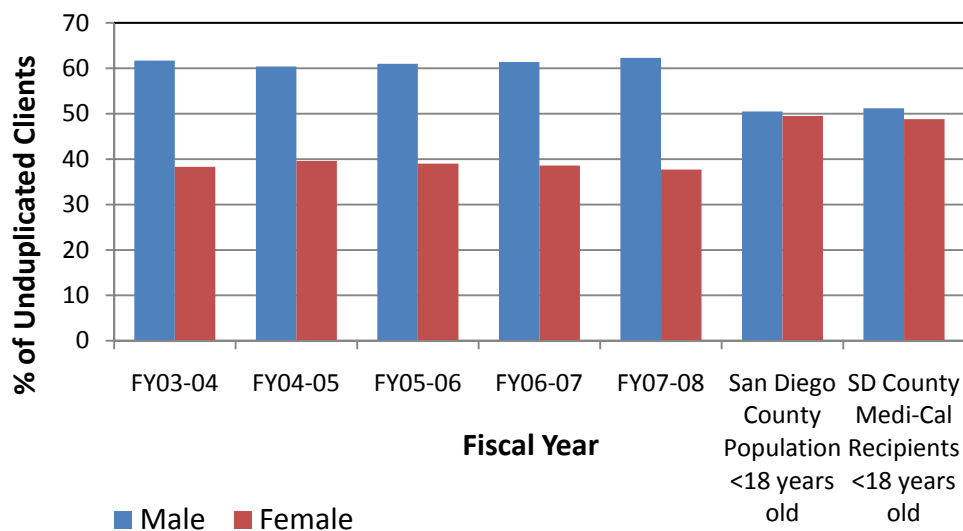
In Fiscal Year 2007-2008, San Diego County delivered mental health services to over 17,600 youth.

- The number of clients receiving services has increased over the past two years.

## Number of Clients by Fiscal Year



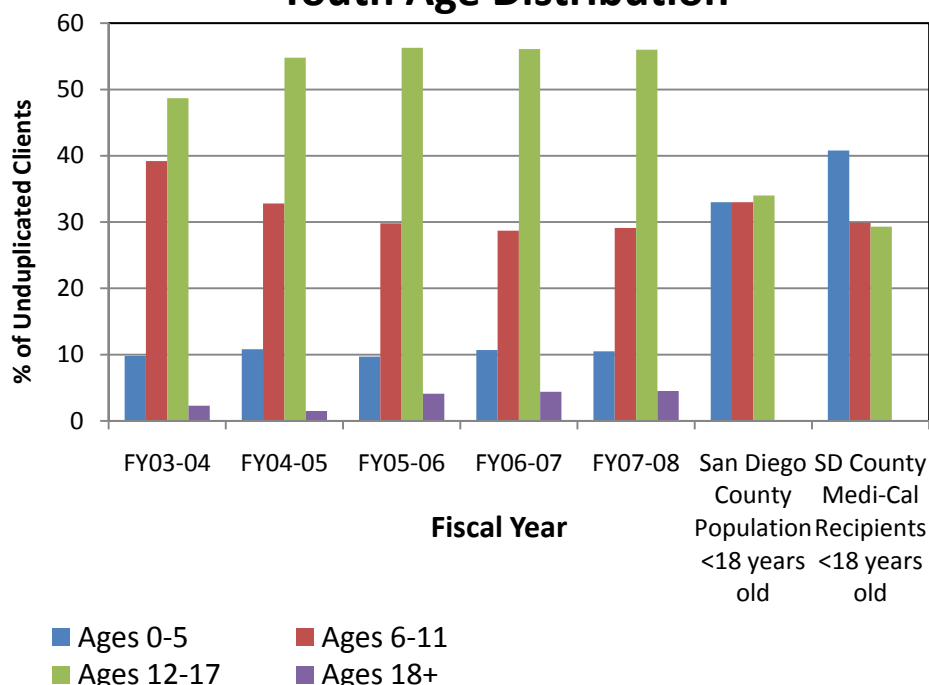
## Youth Gender Distribution



- Over 60% of CMHS clients are male.
- The percentage of clients who are male has increased over the past 4 years.

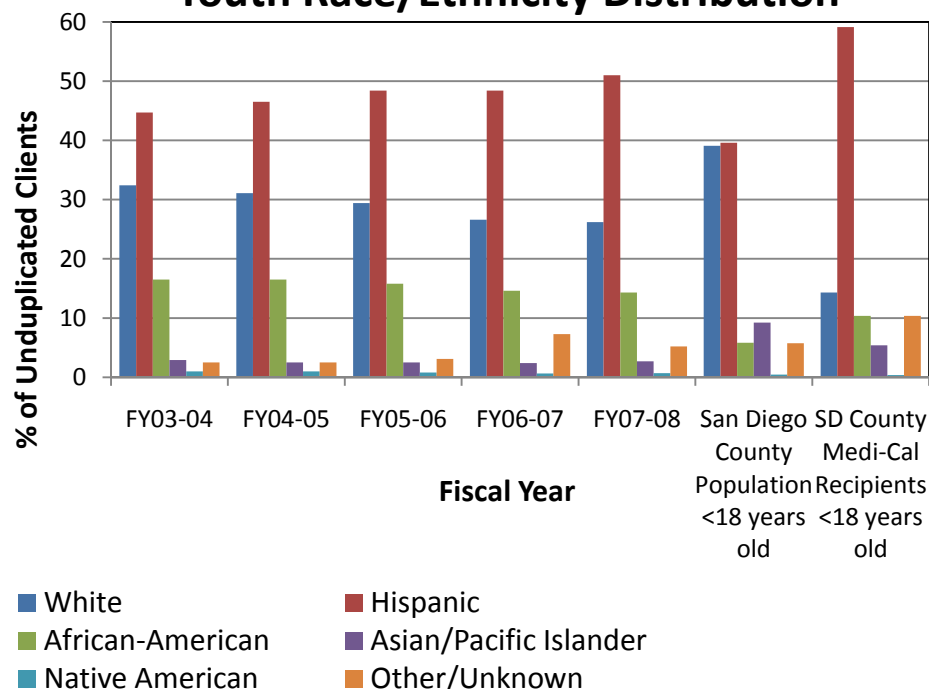
# Youth Receiving Mental Health Services

## Youth Age Distribution



- Adolescents (ages 12-17) make up more than 55% of CMHS clients.
- The percentage of school-aged clients (ages 6-11) has decreased over the past 5 years.
- Youth aged 0-5 comprise about 10% of the CMHS population.

## Youth Race/Ethnicity Distribution



- Hispanic clients have increased over the past 5 years, with over 50% of clients identifying themselves as Hispanic.
- CMHS serves a larger percentage of African-American clients, as compared to their prevalence in the San Diego County youth Medi-Cal population.
- CMHS serves a smaller percentage of Asian/Pacific Islander clients, as compared to their prevalence in the San Diego County youth Medi-Cal population.

# Primary Diagnosis

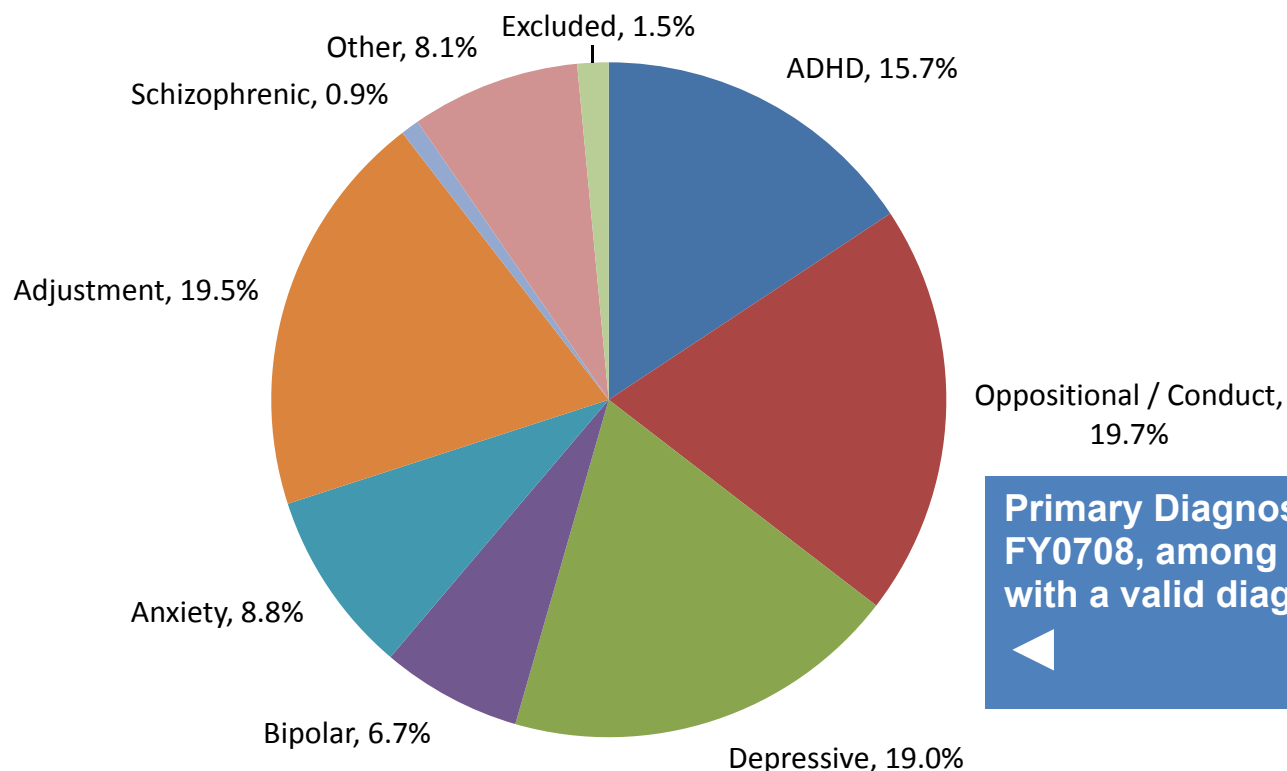
The most **common diagnoses** among youth served by the CMHS are:

- 1) Oppositional Defiant disorders (including Conduct and Disruptive behaviors) (19.7%),
- 2) Adjustment disorders (19.5%),
- 3) Depressive disorders (19.0%),and
- 4) Attention Deficit Hyperactivity Disorder (ADHD) (15.7%)

Diagnosis was determined by identifying the **primary DSM-IV diagnosis** at intake from the last episode of service prior to June 30, 2008. Earlier valid diagnoses were chosen when later episodes reported **invalid diagnoses**, ones in which there was no valid Title 9 or excluded code provided or in which the diagnosis was “diagnosis deferred” (799.9). Only one primary diagnosis was indicated per client for these analyses.

Diagnoses were then grouped into meaningful diagnostic categories according to the Title 9 Medical Necessity Criteria of the California Code of Regulations list of included diagnoses. The **Other** category includes diagnoses such as Pervasive Developmental Disorder (PDD), Asperger’s Syndrome, Paraphilia, Reactive Attachment Disorder, elimination disorders, and eating disorders. **Excluded diagnoses** are those categorized as “excluded” by Title 9 (i.e. autism, learning disabilities).

Note: 3,984 youth receiving mental health services in FY0708 did not have a valid diagnosis entered in INSYST. Most of these youth were seen by FFS or JFS/Spectrum providers, who do not enter diagnoses into INSYST. These youth are excluded from the figure below, resulting in differences between this report and the FY0708 Databook.



**Primary Diagnosis in  
FY0708, among clients  
with a valid diagnosis**



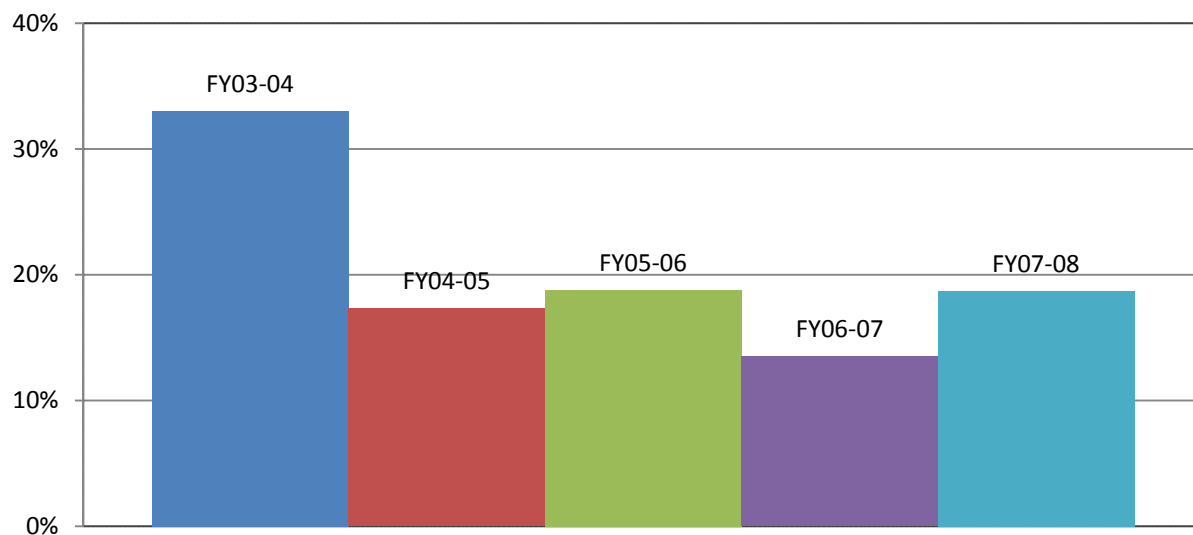
# Dual Diagnosis Youth

The INSYST database allows for providers to enter a **secondary substance abuse diagnosis** for each episode of care, which is also referred to as a **dual diagnosis**. Providers can also indicate a dual diagnosis in the Other Factors field in INSYST.

**273** youth who received CMHS services in FY07-08 (**1.6%** of total CMHS population) had a secondary substance abuse diagnosis or Other Factors field entered in INSYST. This percentage has been unchanged since 2005.

**18.7%** of youth with a dual diagnosis also received services from Alcohol and Drug Services (ADS) during FY07-08, an increase from 13.5% in FY06-07.

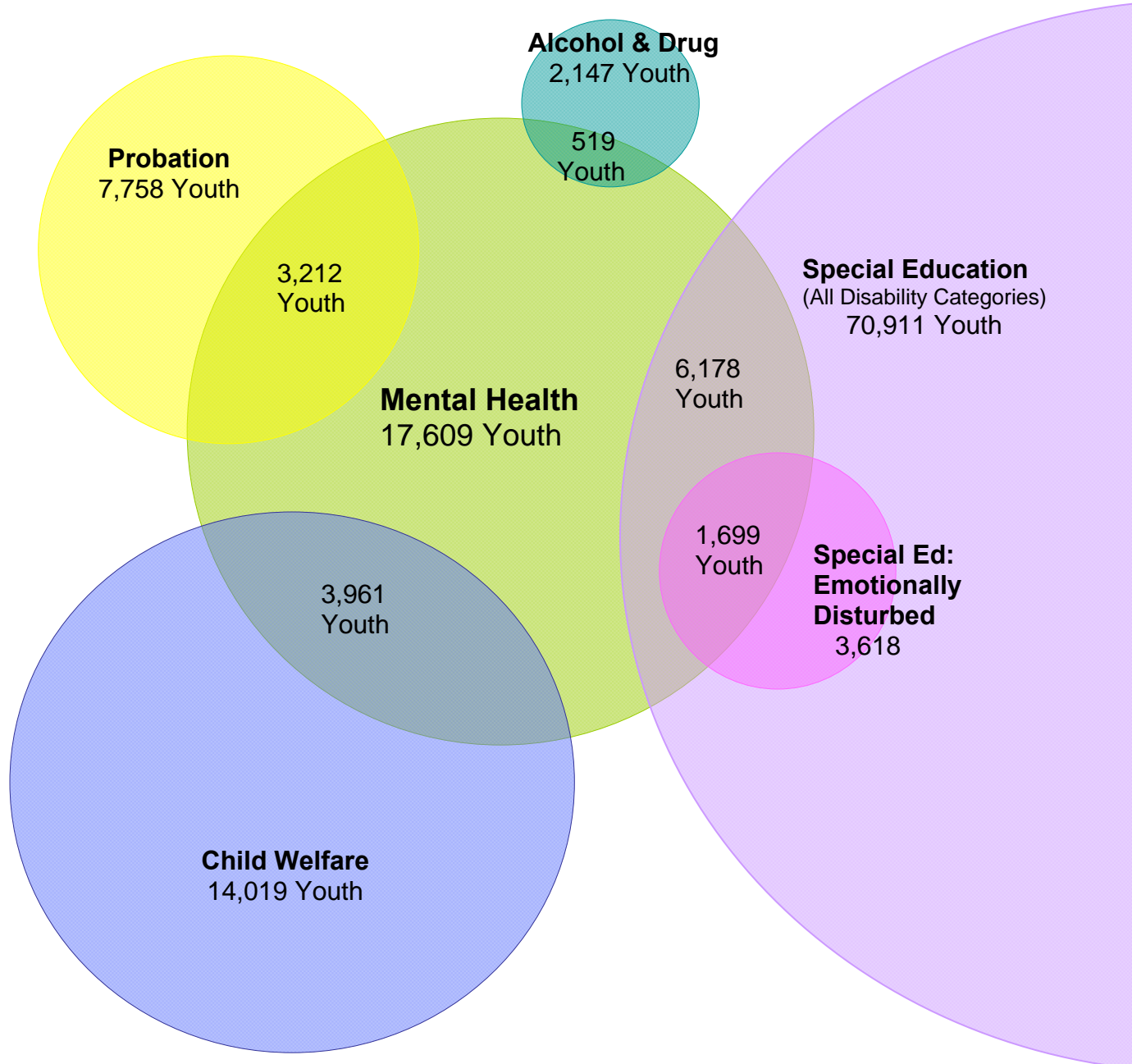
Detailed information on demographics and service use of these youth is available in Appendix G.



**Dual Diagnosis Clients also receiving services from ADS**

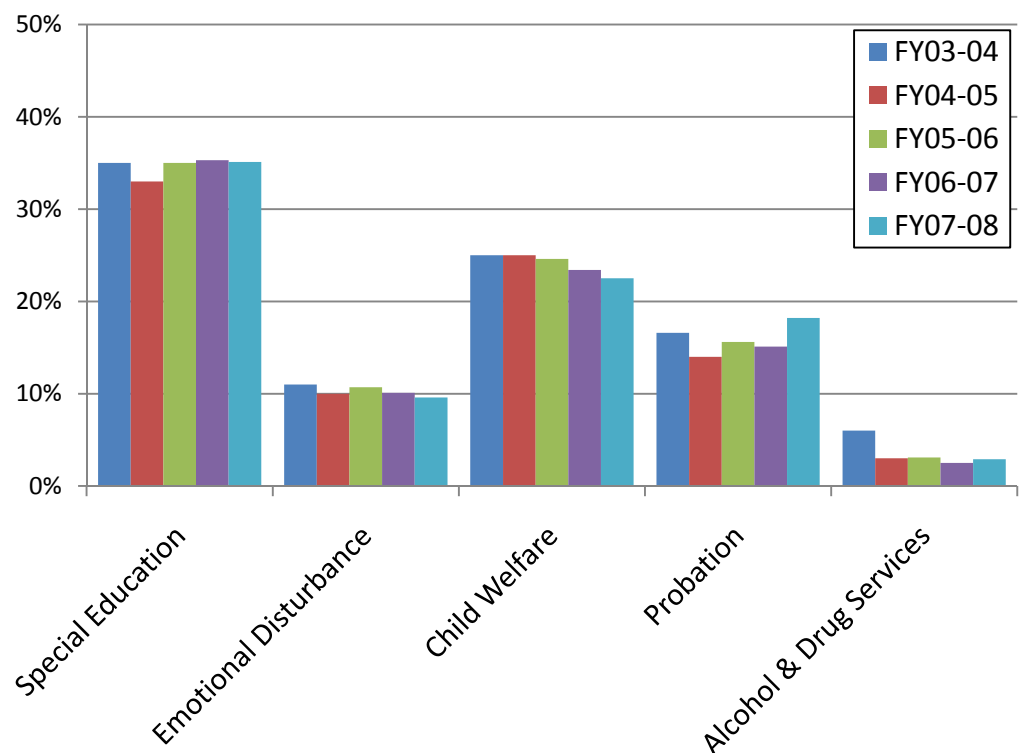
# Multi-sector Involvement

## Youth Receiving Services from Mental Health and Other Sectors – Fiscal Year 2007-2008



# Multi-sector Involvement

- Of the 17,609 youth receiving Mental Health services in FY07-08:
  - 35.1% (N=6,178) also received **Special Education services**,
  - 9.6% (N=1,699) received Special Education services through the **Emotional Disturbance** category (refer to Appendix C for Emotional Disturbance criteria)
  - 22.5% (N=3,961) received **Child Welfare services**,
  - 18.2% (N=3,212) received **Probation services**, and
  - 2.9% (N=519) received **Alcohol & Drug Services** during the fiscal year.
- The percentages of youth receiving services from other public sectors have been **relatively stable** over the past four years.
  - The percentage of CMHS clients also receiving Child Welfare Services has declined consistently since FY04-05.



Percentage of MH  
Clients receiving  
services from  
other sectors

# Youth active to both CMHS and ADS sectors

**Overall, 519 youth receiving CMHS services (2.9%) were also active to Alcohol and Drug Services (ADS) during the fiscal year.**

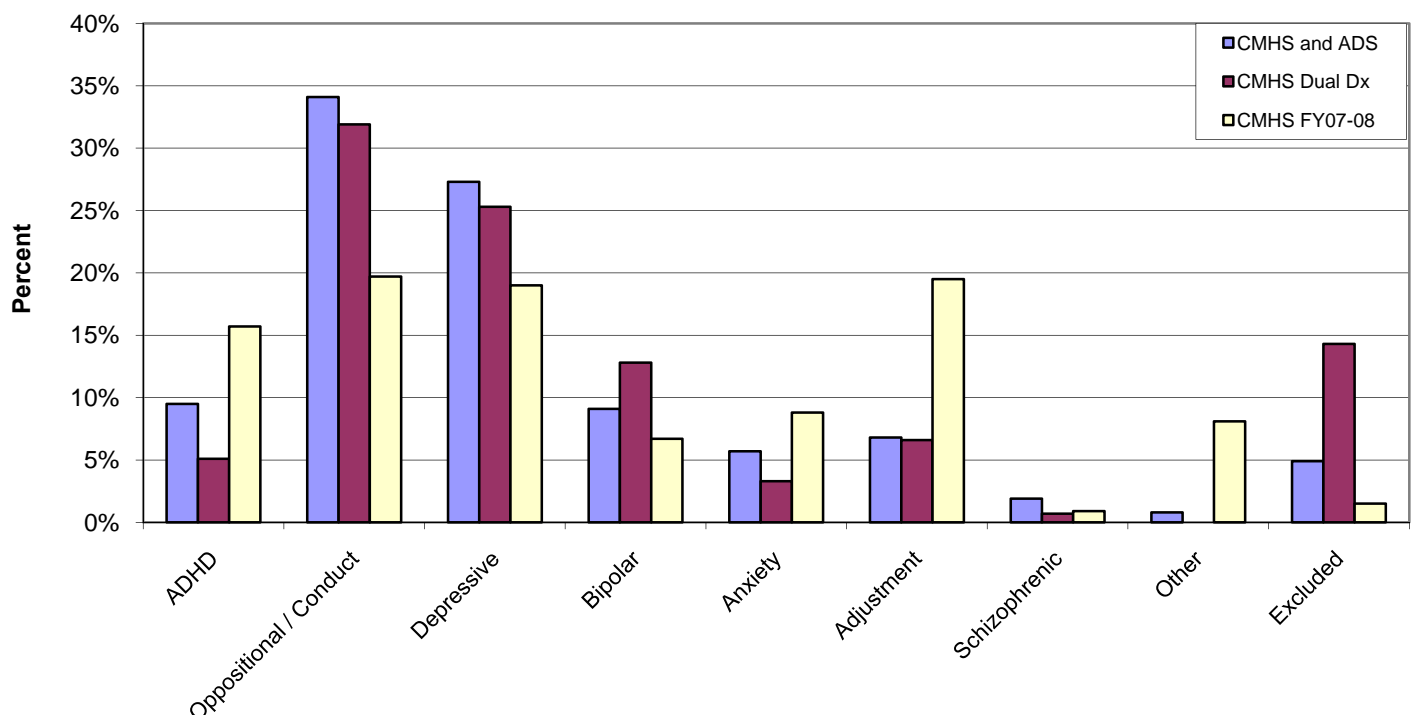
Being active to both sectors is an indication that they have both mental health and substance use needs serious enough to warrant treatment. Detailed information on demographics and service use of these youth is available in Appendix G.

**18.7% of the 519 youth active to both the CMHS and ADS sectors also had a dual diagnosis** in the mental health system. The percentage of youth active to both CMHS and ADS who have a dual diagnosis in CMHS has remained below 25% over the past 5 years.

This indicates that the mental health provider is either unaware of the youth's co-occurring substance use issue or did not enter the dual diagnosis into the mental health system.

**Youth active to both CMHS and ADS were more likely to have primary diagnosis of an oppositional/conduct or depressive disorder than youth in CMHS overall. This pattern has been consistent over the past 5 years.**

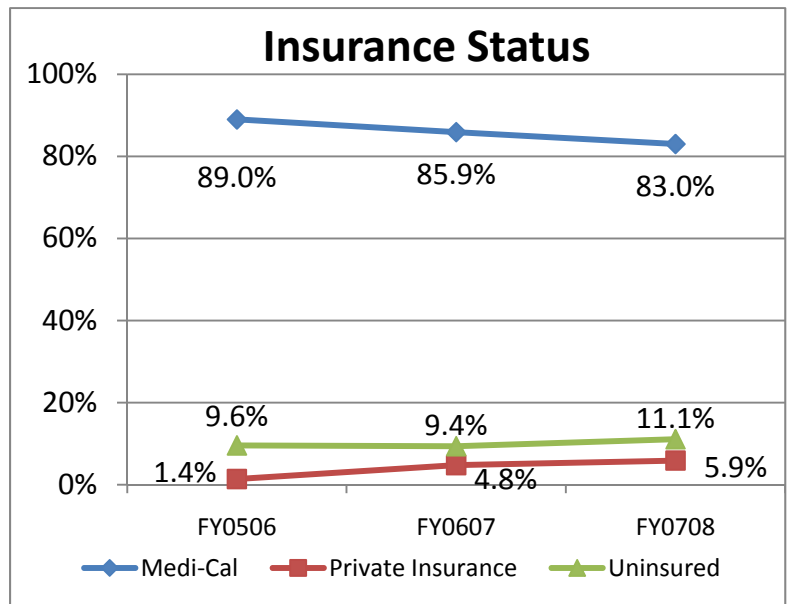
**Primary diagnosis for youth active to CMHS and ADS**



# Insurance & Housing Status

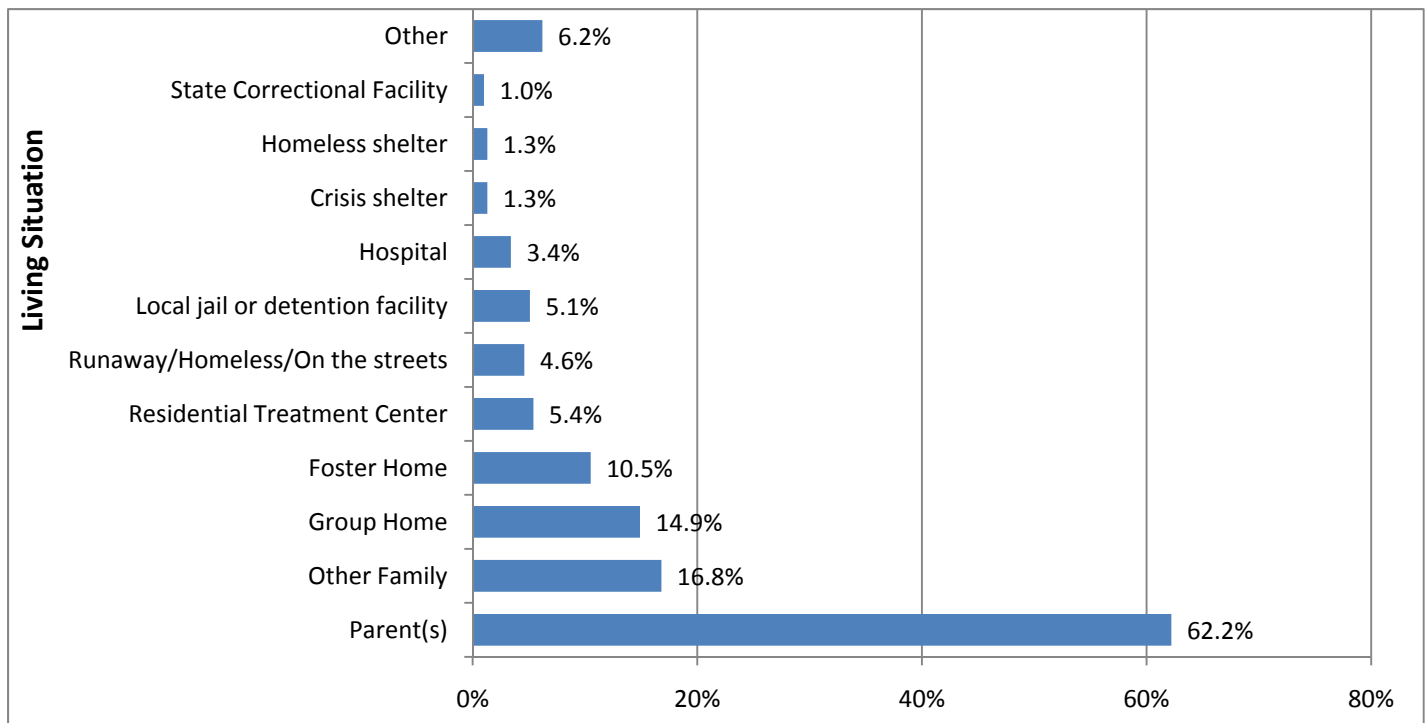
Insurance status was determined by examining billing records for each service visit. **83% of clients used Medi-Cal at least once during FY07-08.** The percentage of clients with Medi-Cal has decreased steadily since FY0506.

Respondents are also asked about Medi-Cal status on the December 2007 and May 2008 Youth Services Survey. 80.3% of parents (N=5722) reported that their child had Medi-Cal coverage at the time of the survey.



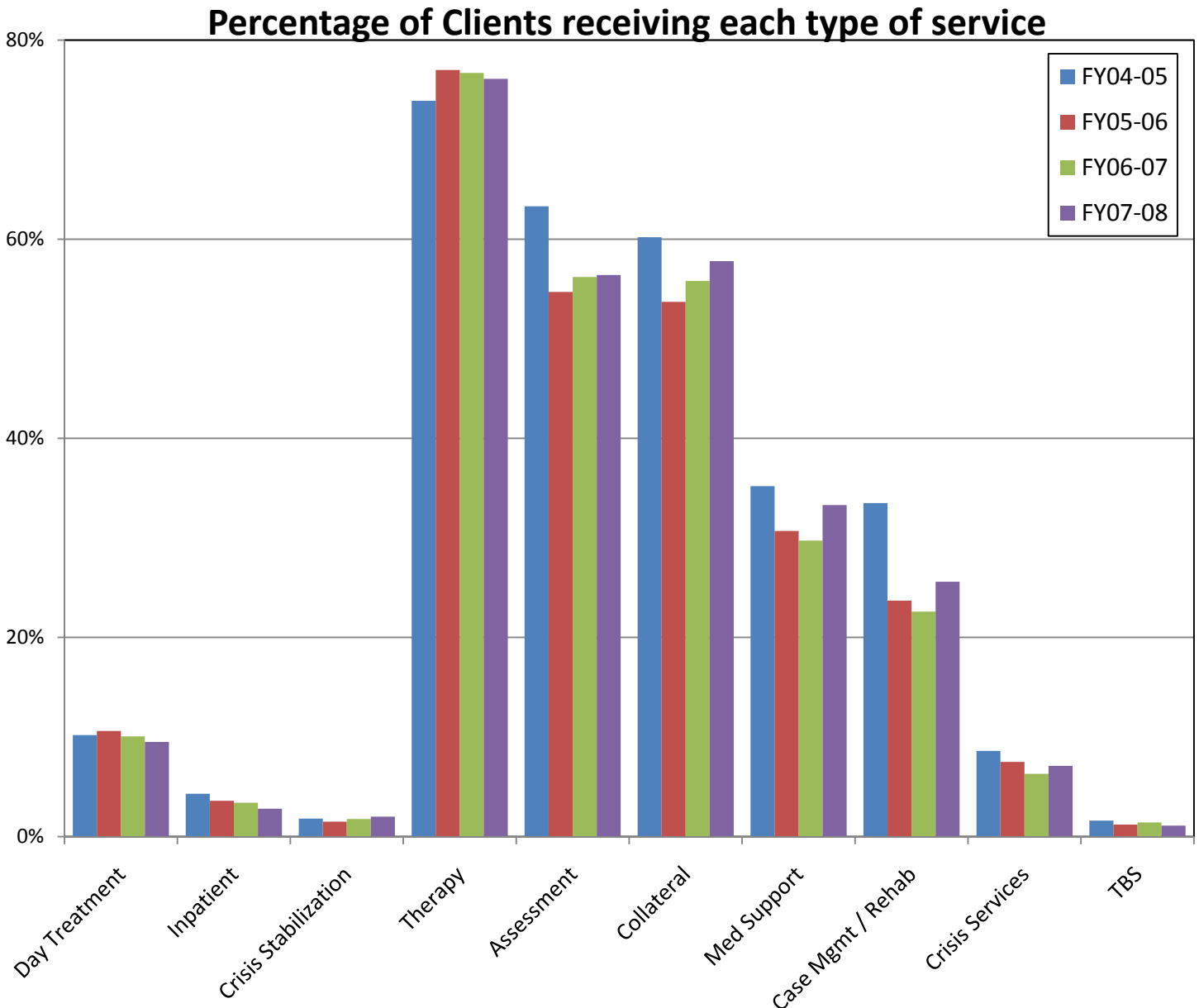
On the December 2007 and May 2008 Youth Services Survey, 3,077 youth, ages 13 and older, responded to a question about their living situations during the past 6 months.

**Over one third of youth reported they did not live with their parents at some point in the past six months .**



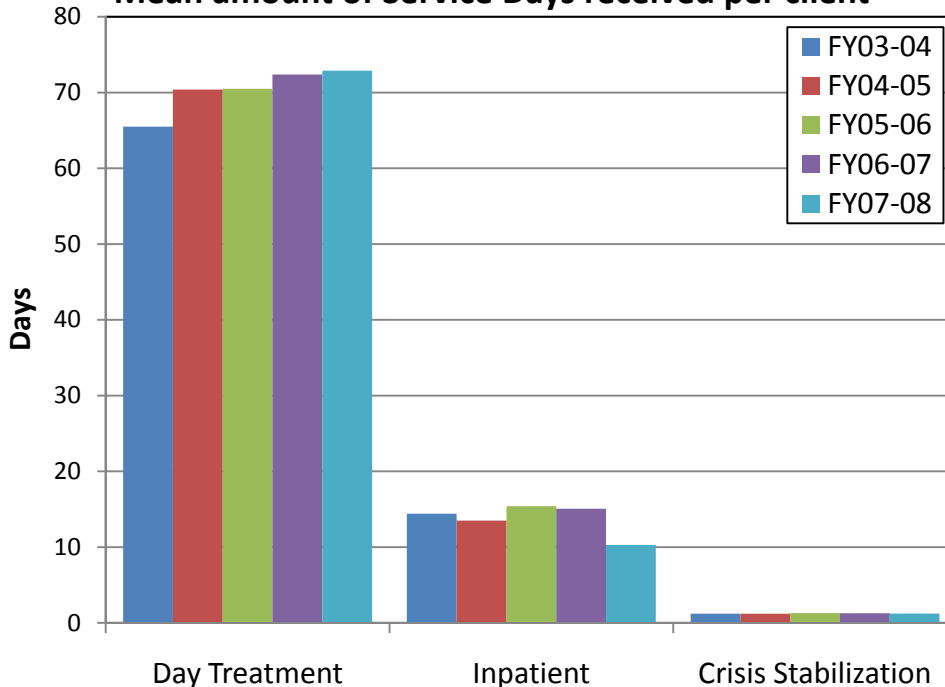
# Service Utilization by Client Characteristics

Children and youth may receive multiple services in the course of a year, and the amount of each service received can vary widely by client. Services were determined by examining the procedure code for each billed service. Refer to the Glossary in Appendix A for a description of service types.



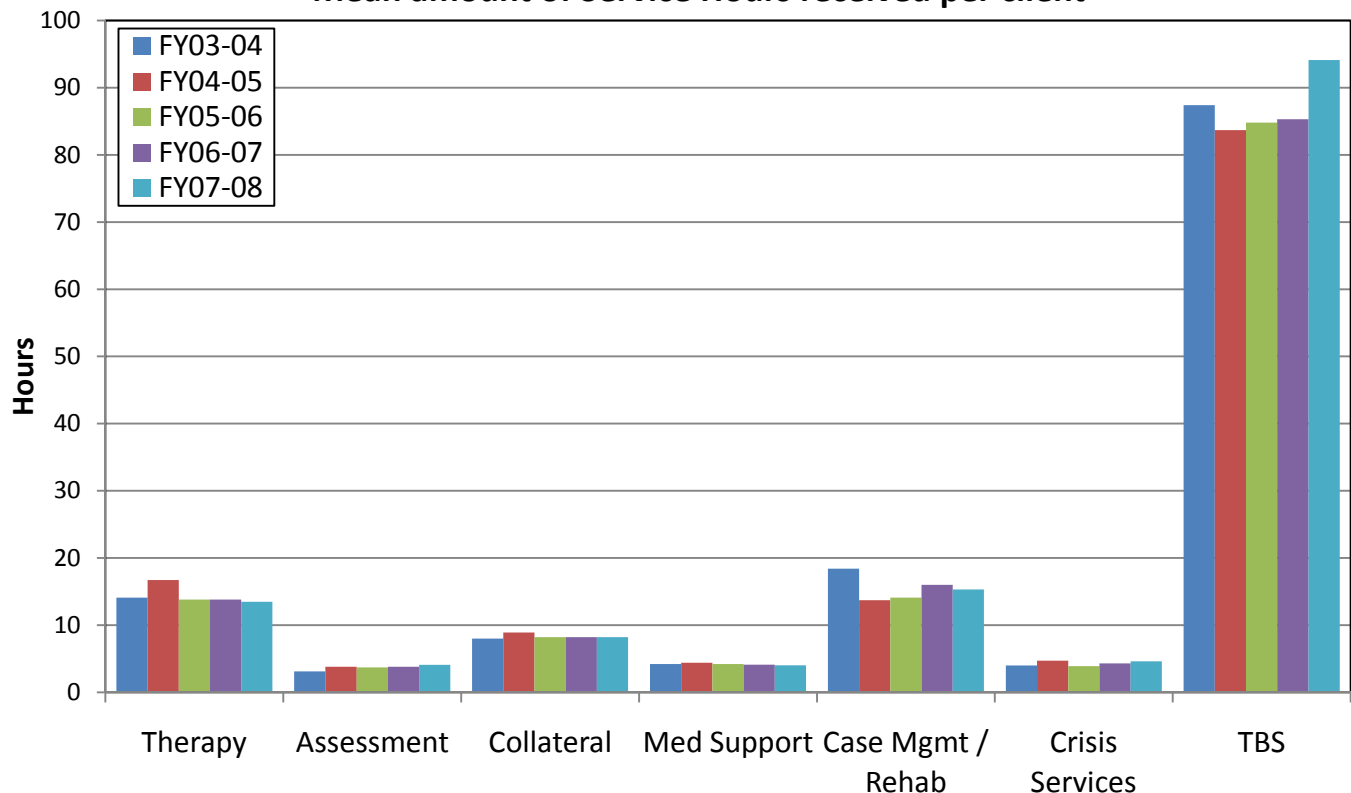
# Service Utilization by Client Characteristics

**Mean amount of Service Days received per client**



- The number of days of **Day Treatment service** has **increased steadily**, from 66 in FY03-04 to almost 73 days per client receiving day treatment services in FY07-08.
- On average, clients received **13.5 hours of therapy services** in FY07-08.

**Mean amount of Service Hours received per client**



# Service Utilization by Client Characteristics

Detailed data tables on service utilization by client characteristics are available in Appendix F. Major findings are summarized below.

## Primary diagnosis:

- As expected, youth with a **bipolar or schizophrenic diagnosis used more services** on average than youth with other diagnoses.
  - They were more likely to use services and to use more hours of service, particularly in the case management and medication support categories.
  - They were more likely to use inpatient hospital days (9.2% and 28.1% respectively as compared to 3.6% for the sample overall) in FY07-08.
  - They were more likely to use intensive day treatment services.
  - These findings have been consistent over the past 4 years.

**As expected, youth with a bipolar or schizophrenic diagnosis used more services on average than youth with other diagnoses.**

## Race/Ethnicity:

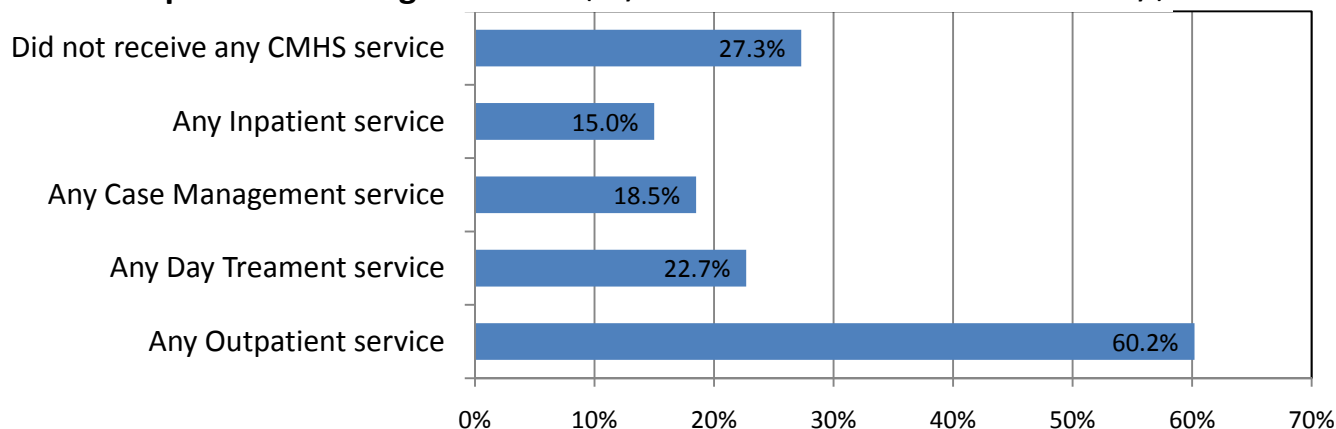
- There are **few differences** in service utilization by youth race/ethnicity.
- Children in the **Other/Mixed racial/ethnic category were less likely to use services**, as compared to children in the Hispanic, Black, White, Asian/Pacific Islander, or Native American racial/ethnic groups.

# Inpatient & ESU Service Use

**Inpatient Clients:** Detailed information on clients using Inpatient (IP) Services can be found in Appendix G.

- 492 clients (2.8%) used inpatient services in FY07-08
  - 79.5% of these clients were ages 12-17
  - For 36 clients (7.3%), Inpatient services were the only service used during FY07-08
- Top 3 primary diagnoses: 44.9% Depressive disorders, 17.1% Bipolar disorders, 17.1% Oppositional / Conduct disorders
- 107 clients (21.7% of the IP sample) had more than one IP episode in the fiscal year
  - 74 clients (15.0% of the IP sample) were re-admitted to IP services within 30 days of the previous IP discharge.
- 129 IP clients (27.3%) received no other CMHS services within 30 days after IP discharge.

**Percentage of clients receiving CMHS services within 30 days of Inpatient Discharge - FY0708** (may have received more than one service within 30 days)



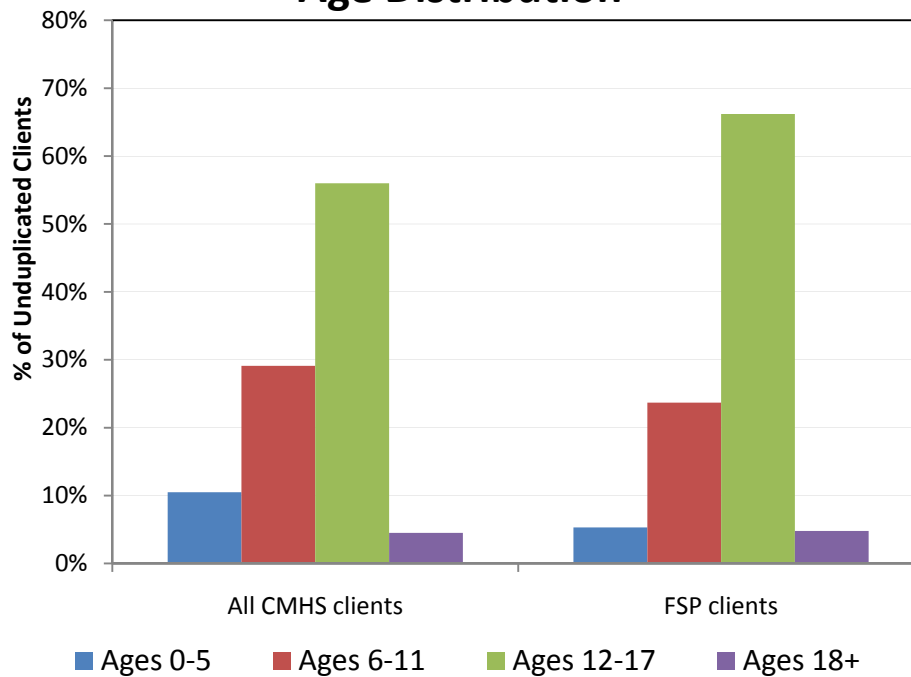
## Emergency Screening Unit (ESU) clients:

- 848 clients (4.8%) used ESU services in FY07-08
  - 77.4% of these clients were ages 12-17
  - For 216 clients (25.5%), ESU services were the only services used during FY07-08
- Top 3 primary diagnoses: 39.7% Depressive disorders, 22.1% Oppositional / Conduct disorders, and 9.9% Bipolar disorders
- 328 clients (38.7% of the ESU sample) had more than one ESU episode in the fiscal year
  - 283 clients (33.4% of the ESU sample) were re-admitted to ESU services within 30 days of the previous ESU discharge.
- 188 ESU clients (23.9%) received no other CMHS services within 30 days after ESU discharge.

# Full Service Partnership (FSP) Programs

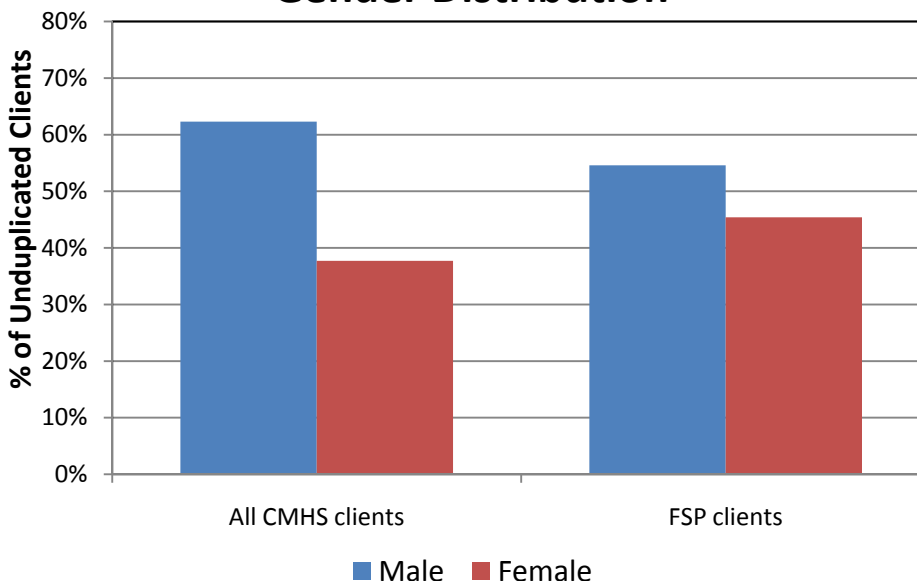
Full Service Partnership (FSP) programs are comprehensive programs which provide all necessary services and supports, including intensive services, to clients with a high level of need to enable them to live in their community. Examples include the Cultural Access and Resource Enhancement program, Fred Finch wraparound services for youth involved in Child Welfare, and the Counseling Cove services for homeless and runaway youth. **In FY0708, 228 unduplicated clients received services through the FSP programs.**

## Age Distribution



- Almost two-thirds of the FSP clients in FY0708 were adolescents.

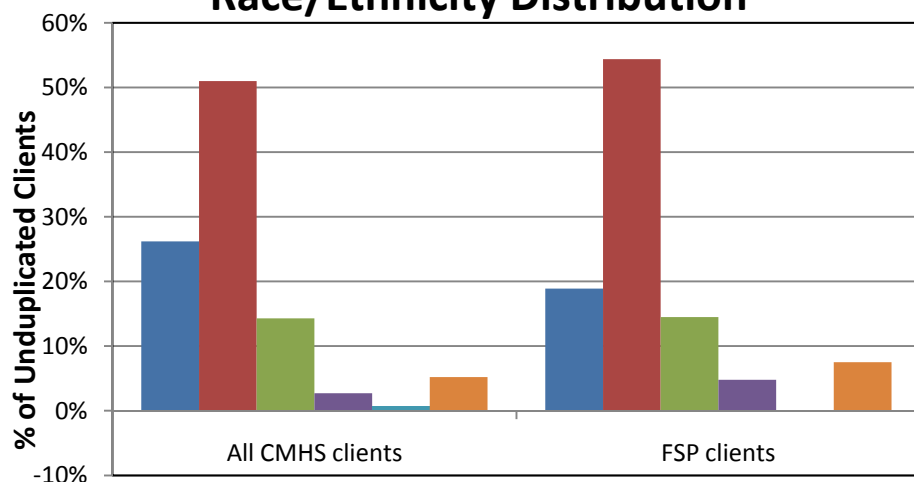
## Gender Distribution



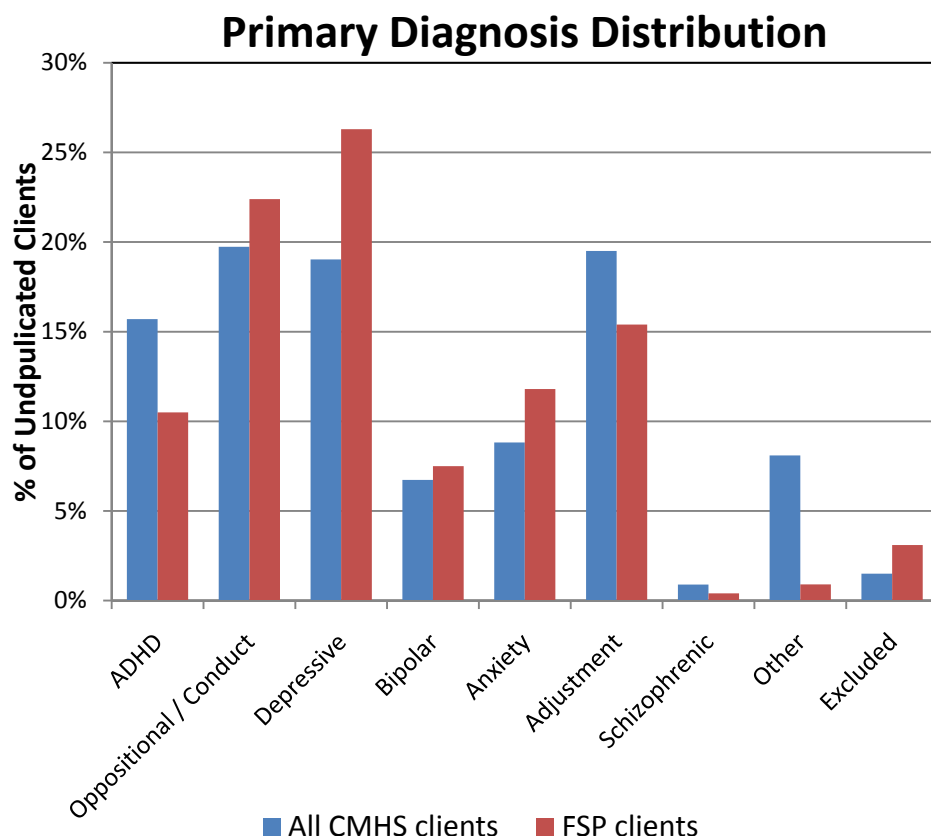
- The gender distribution is more balanced in the FSP population than in the overall CMHS population.

# Full Service Partnership (FSP) Programs

## Race/Ethnicity Distribution



- A larger percentage of **Hispanic and Asian/Pacific Islander youth** receive services through FSPs than in the overall children's mental health system.



- FSP clients are more likely to have a primary diagnosis of a **depressive disorder or an oppositional/conduct disorder** than youth in the overall CMHS population.

Note: 4 FSP clients did not have a valid diagnosis entered in INSYST.

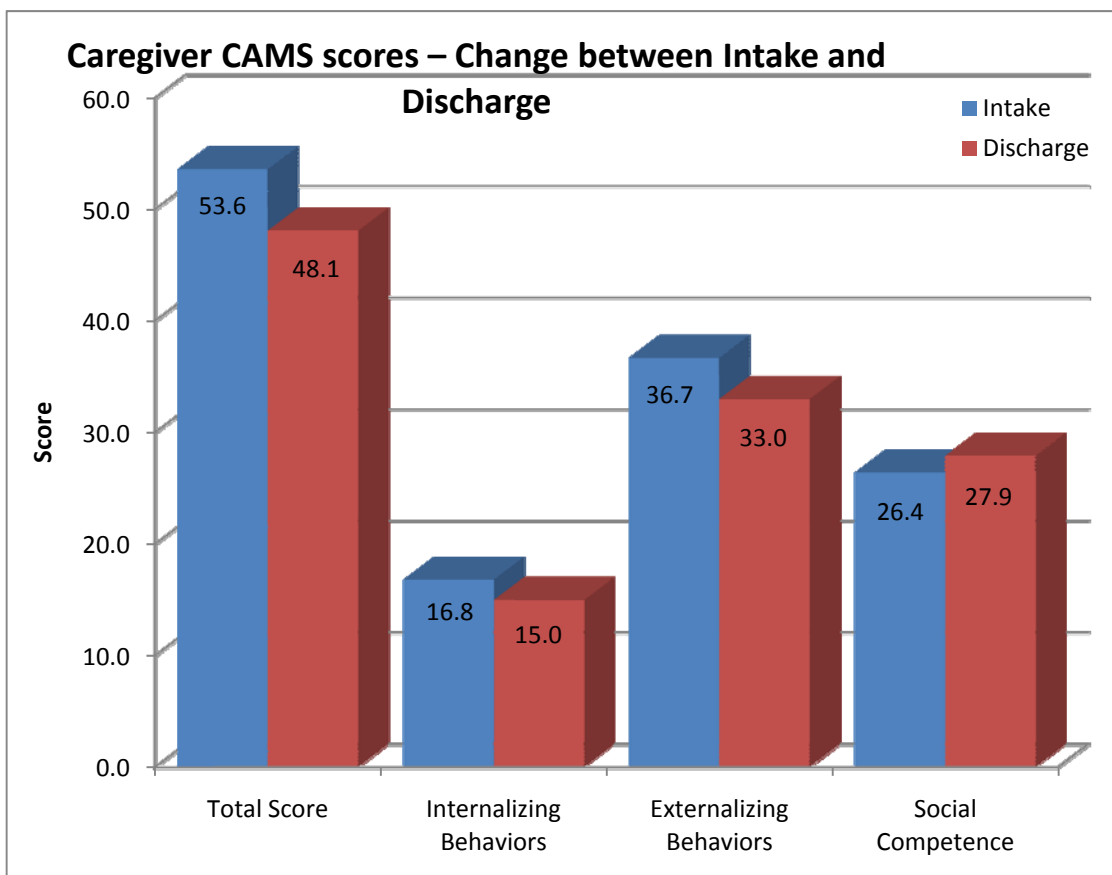
# Client Outcomes

San Diego County tracks outcomes for youth served by CMHS through the **System of Care Evaluation (SOCE)**. In Fiscal Year 2007-2008, the outcomes measures included:

- the Child and Adolescent Measurement System (CAMS)
- the Children's Functional Assessment Rating Scale (CFARS)
- the Youth Services Survey (YSS)

Based on input from youth and caregivers, youth experienced significant improvements between Intake and Discharge, as measured by the CAMS.

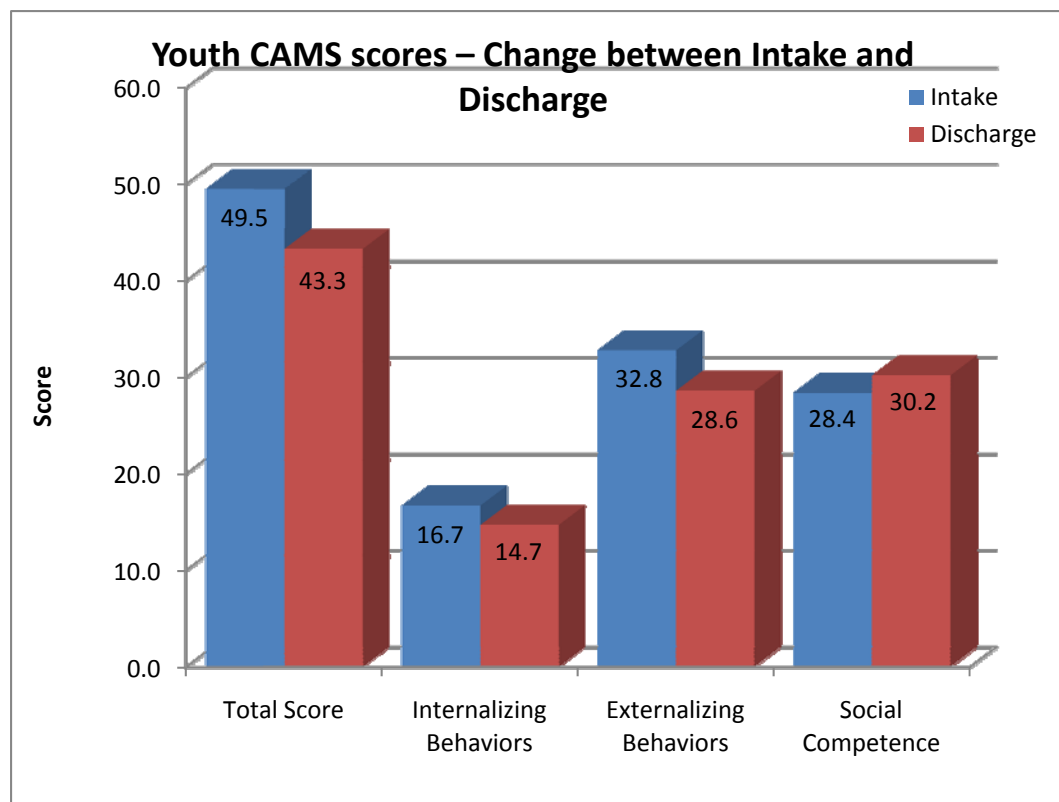
The CAMS, a measure of youth symptoms and behavior, is completed by all parents/caregivers, and youth ages 11 and older, at Intake, each utilization review time point, and Discharge. CAMS scores were examined for youth discharging from services in FY0708 who had both Intake and Discharge scores (N=1205 Parent CAMS and N=651 Youth CAMS).



Note:

- A decrease on the Total, Internalizing, or Externalizing CAMS score is considered an improvement.
- An increase in the Social Competence score is considered an improvement.

# Child & Adolescent Measurement System (CAMS)



**Both Caregivers and Youth reported Significant Improvements between Intake And Discharge on all CAMS scales.**

Analyses were done to see if there were differences in improvement on the Parent and Youth CAMS (total, internalizing and externalizing subscales) based on youth age, gender, and race/ethnicity (Black, Hispanic, White, Other).

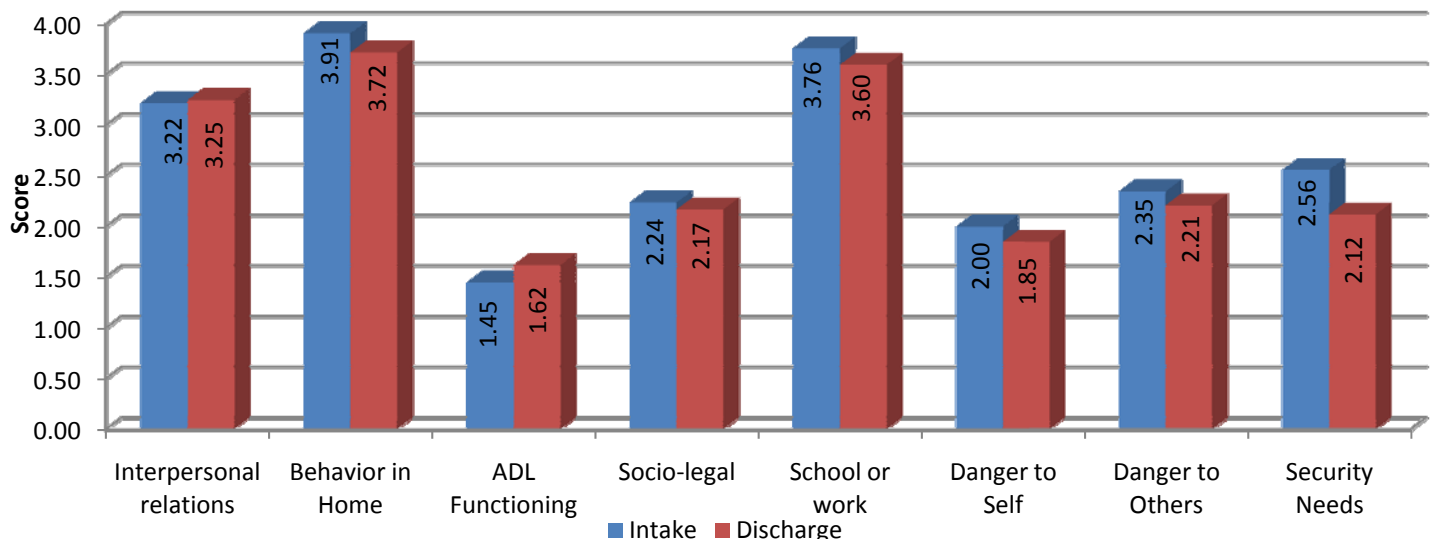
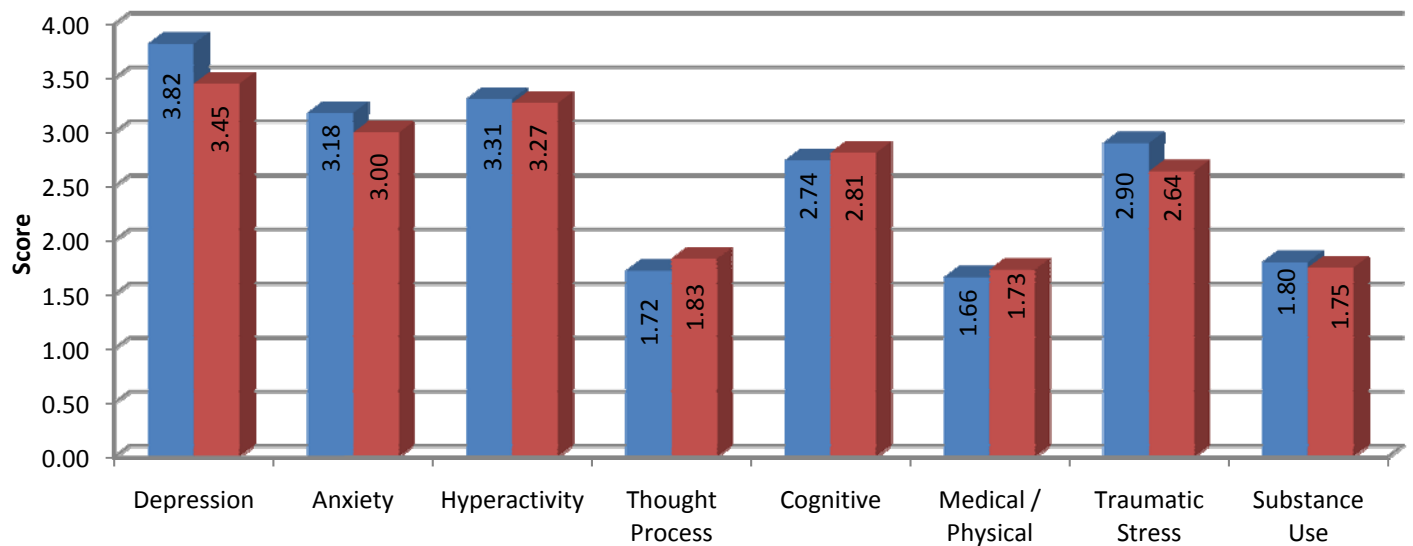
- Parents of Hispanic youth were **significantly more likely to report improvement** on the 3 CAMS scales than were parents of youth in the three other racial/ethnic groups.
  - This difference was not seen on the Youth CAMS.
- No other significant differences were present by age, gender, or race/ethnicity.

# Children's Functional Assessment Rating Scale (CFARS)

Outcomes data is also collected through the CFARS, or Children's Functional Assessment Rating Scale. This measure, which was introduced in August 2007, allows for the clinician to give direct input on outcomes and provides information in cases where the CAMS is not available. Data was available on 2,435 clients who discharged in FY0708 and had both Intake and Discharge CFARS scores available.

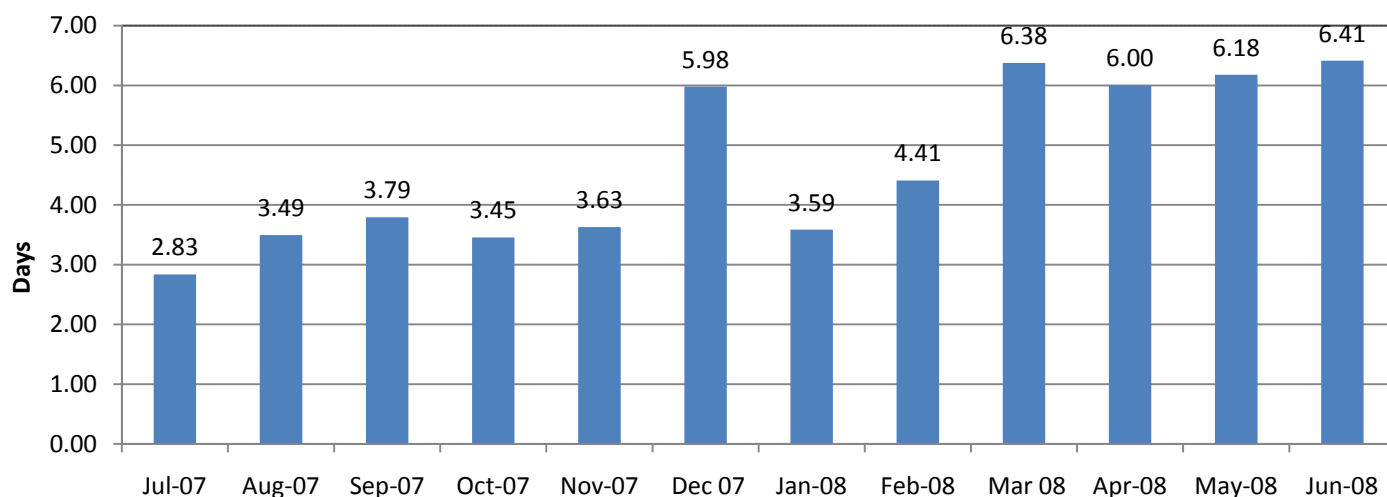
CFARS scores are difficult to examine at the system level, as it is not expected at all clients will be impaired in multiple areas. Examination of data from this pilot year of CFARS use shows great variation between the domains. During the coming year, we will continue to examine the CFARS scores over time at the client level to determine whether the patterns being seen are appropriate.

**CFARS Scores (Clinician report) – Scores at Intake and Discharge**

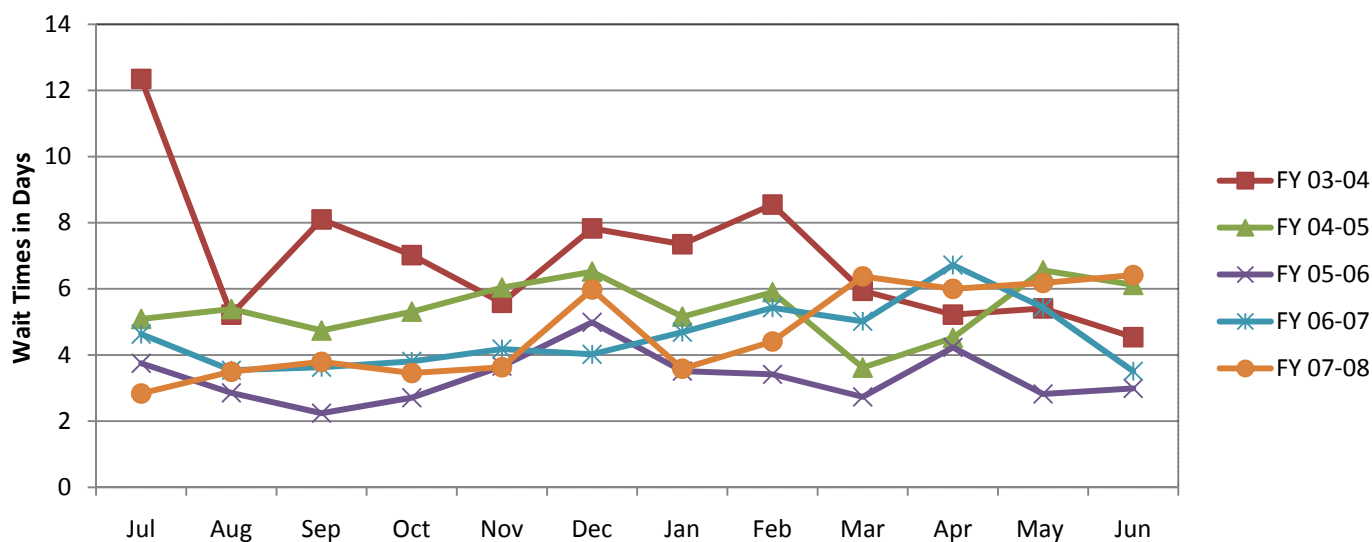


- In FY07-08, children waited an average of **4.68 days** to receive services; the goal of a wait time of less than 5 days has been met.
- Wait times vary significantly by program, with some sites having a long wait to receive services and others being able to offer immediate access.

## Children's Mental Health Services Average Wait Times FY 07-08



## Children's Mental Health Services Average Wait Times (days) - Comparison by Fiscal Year



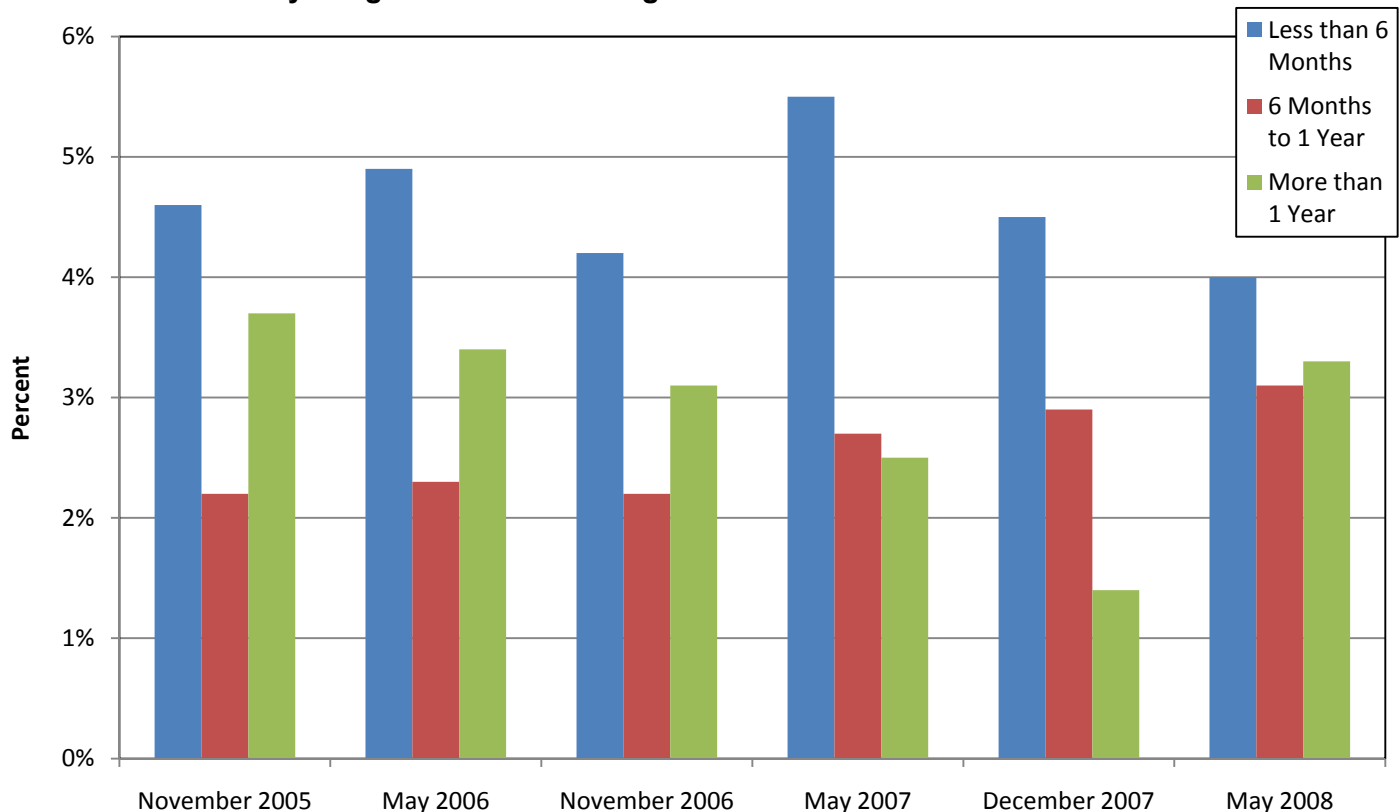
# Arrests

The **Youth Services Survey (YSS)** provides data regarding two outcomes areas of interest to the County: arrests and substance use. The YSS gives a snapshot in time of how youth receiving services through CMHS look, and allows us to examine data by the length of time a client is in service. The YSS was administered to clients during 2 two-week periods in December 2007 and May 2008, and was completed by all clients, ages 13 and older, as well as the parents/caregivers of all youth receiving services regardless of age.

In the **Youth Services Survey**, both the youth (ages 13+) and parent respondent were asked to report on whether the youth had been **arrested for any crimes in the past month**, and if so, how many times the youth had been arrested. 7,505 respondents answered the arrest question in FY07-08.

- **6.7% of youth receiving services from CMHS reported being arrested in the month prior to the survey.** Youth were significantly more likely to self-report having been arrested, as compared to parent report of youth arrests.

**Past Month Arrests by Length of Time receiving Services**

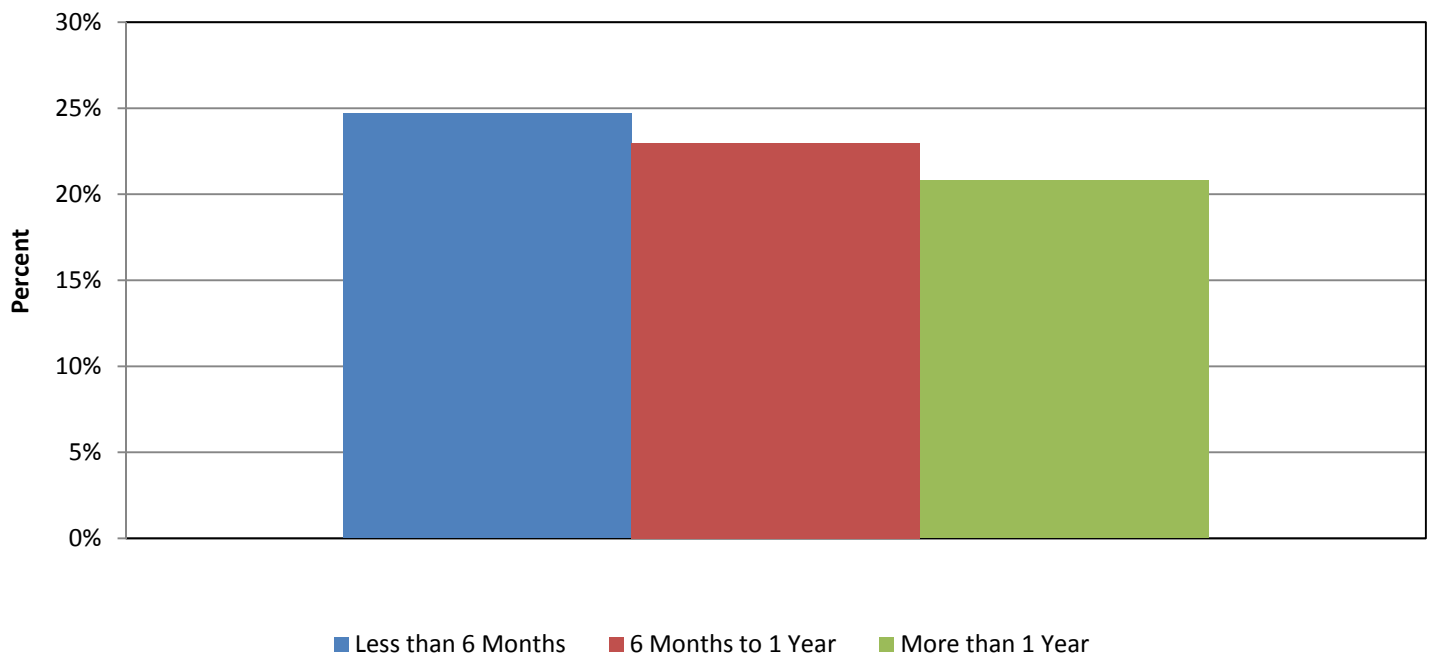


# Substance Use

In the YSS, youth age 13+ were asked whether they had used any of a list of substances (alcohol, cigarettes, ecstasy, cocaine, marijuana, crystal meth, inhalants, hallucinogens, opiates, injected drugs) in the past month. 2,900 youth answered the substance use question in FY07-08.

- Overall, **23.3% of youth** stated that they had used one of these substances at least once in the past month.
- **18.3%** of youth stated they had used a substance **other than cigarettes** at least once in the past month.
- According to youth, the **three most commonly used substances**, in descending order, were cigarettes (13.3% in past month), alcohol (13.1%), and marijuana (11.0%).
- When reports of substance use on the YSS were examined by the length of time receiving CMHS services, there is a non-significant trend ( $p=0.13$ ) towards a decrease in past month use of substances as the youth's time in mental health services increases.

**Youth Report of Past Month Use of Substances by Length of Time receiving Services**



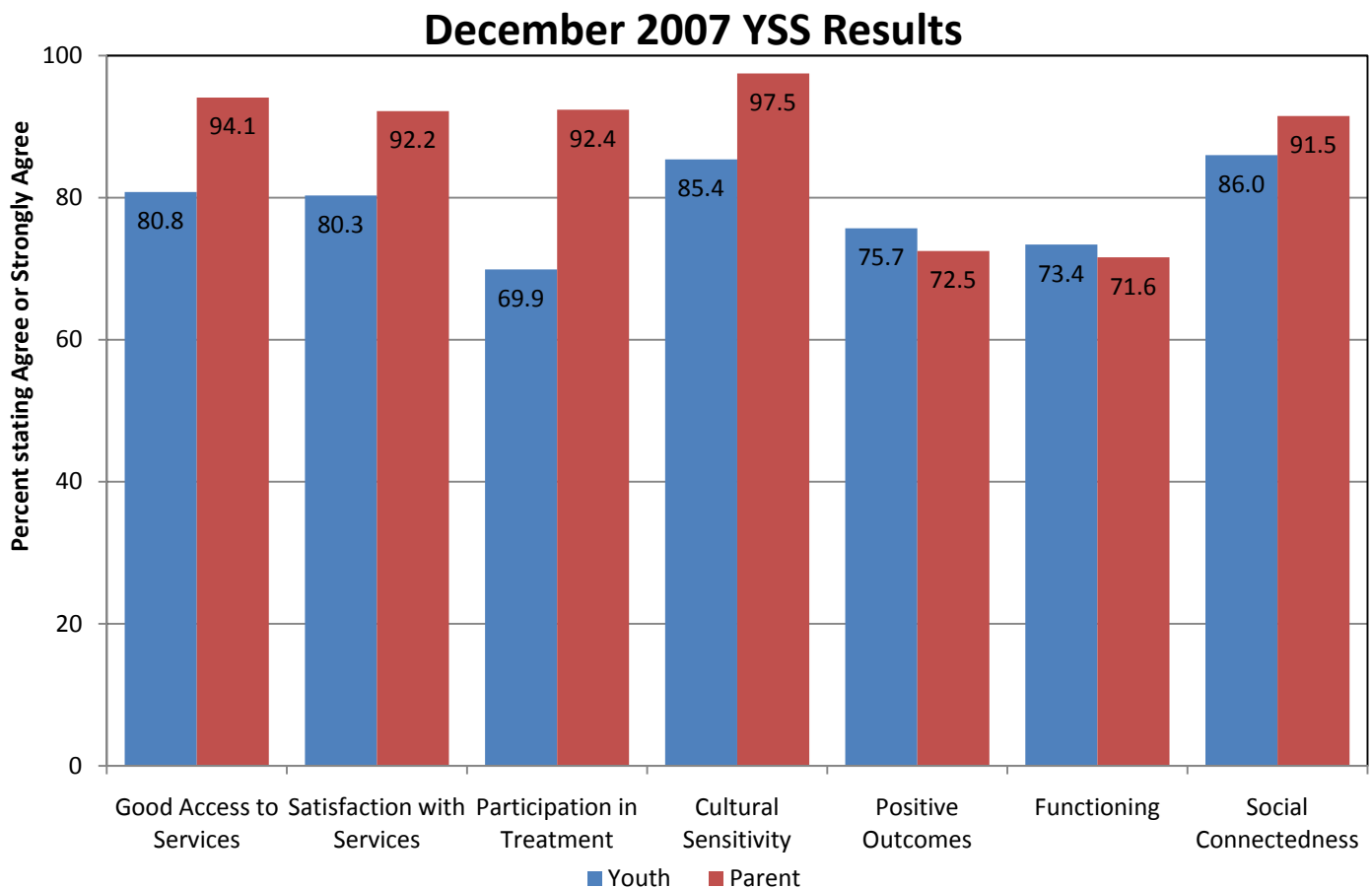
# Satisfaction

During FY0708, data on consumer satisfaction was collected through the state-mandated Youth Services Survey (YSS), which was completed between December 1-15, 2007 and May 12-23, 2008.

A total of 7,778 surveys were completed by youth, ages 13+, and parents/caregivers during the December 2007 and May 2008 collection periods.

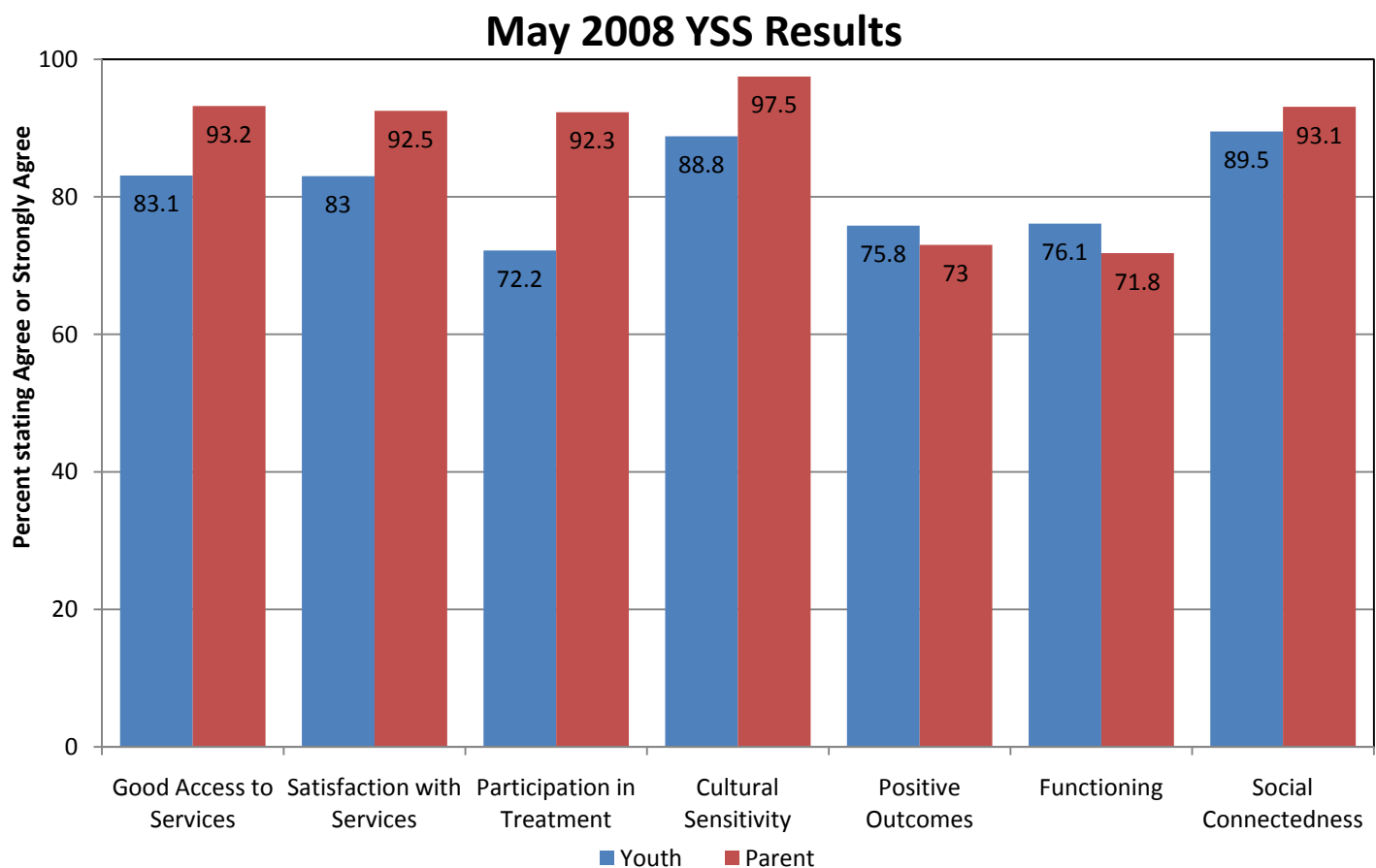
YSS questions were grouped into seven domains:

- Good Access to Services
- Satisfaction with Services
- Participation in Treatment
- Cultural Sensitivity
- Positive Outcomes
- Functioning
- Social Connectedness.



## Key YSS Findings:

- Parents/caregivers are more satisfied than youth on 5 of the 7 domains. This pattern has been found in other studies of parent and youth satisfaction and may reflect the youths' perception of limited choice in their own treatment decisions (e.g. parent decides that youth needs care as opposed to youth deciding, etc.).
- Differences were most pronounced on the Participation in Treatment domain.
- Youth reported slightly higher satisfaction than parents on the Positive Outcomes and Functioning domains.
- These patterns have been consistent for the past three years.

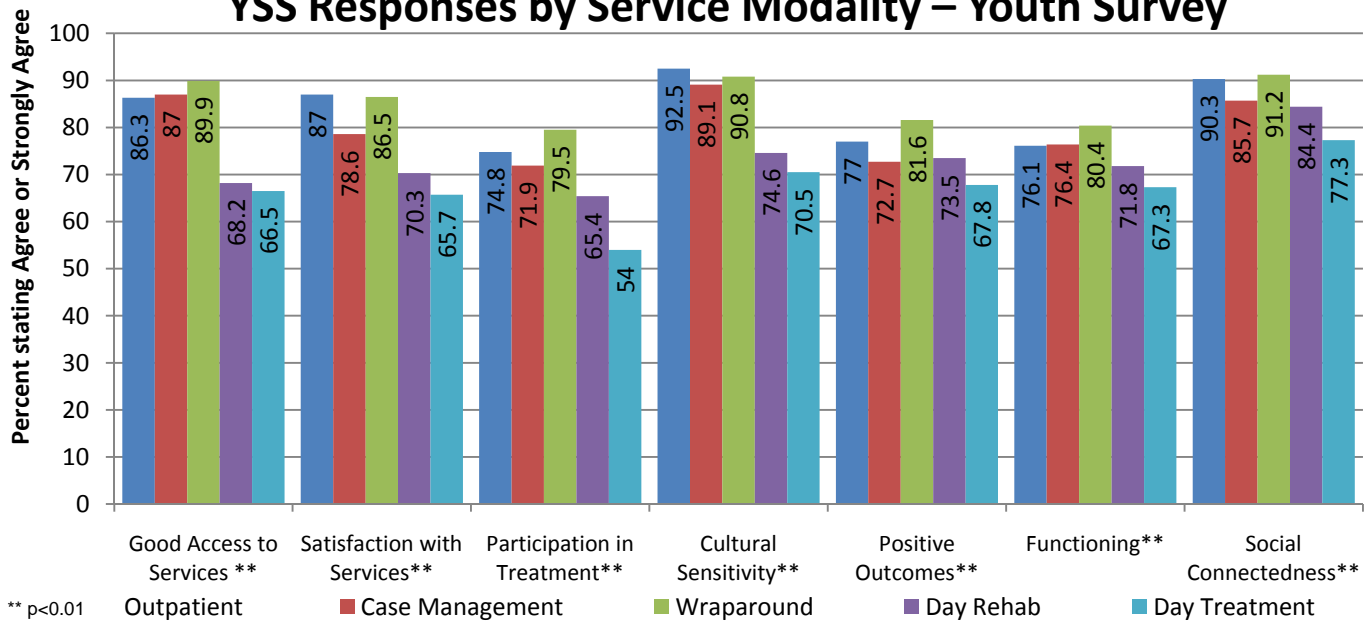


# Satisfaction

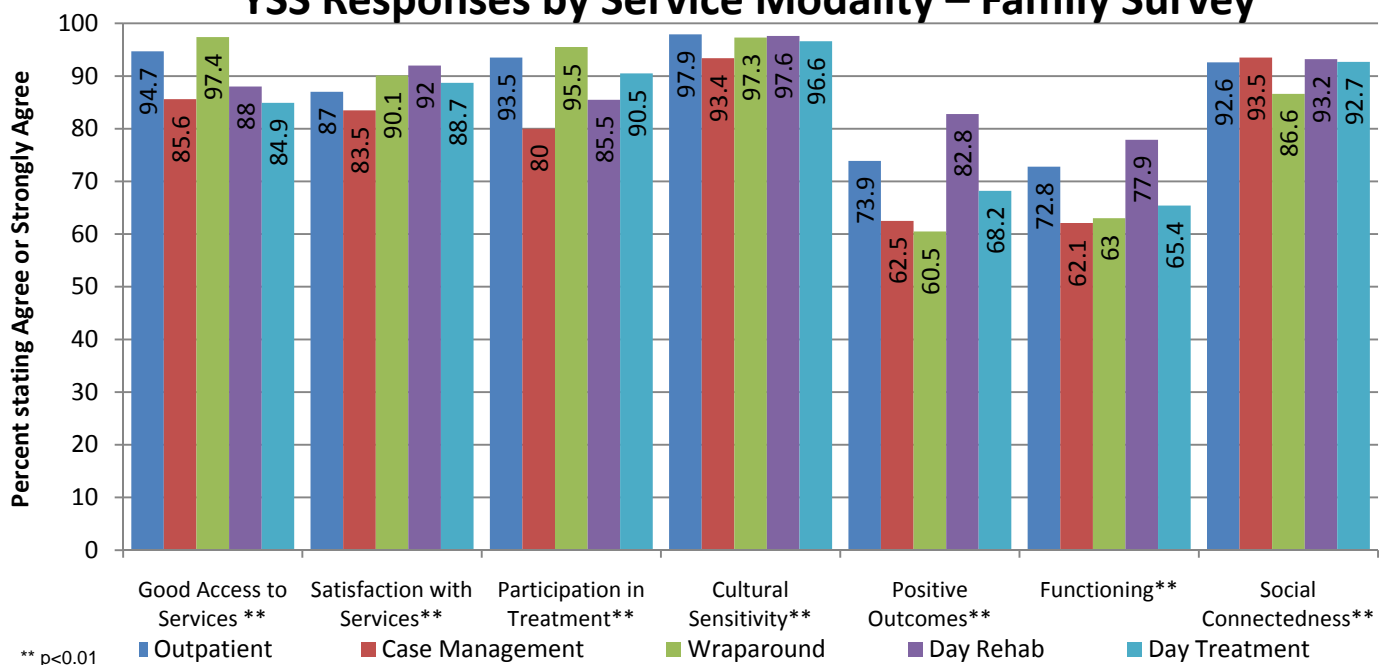
Results from the FY07-08 YSS also show significantly different levels of satisfaction by the **service type** received by the youth.

- Youth receiving day treatment services reported **lower levels of satisfaction** in all seven domains, as compared to the other service groups.
- **Cultural Sensitivity** has the highest scores across the modalities for both youth and parent respondents.
- **Parent scores are higher on average** than the youth scores, except in the areas of Positive Outcomes and Functioning.

## YSS Responses by Service Modality – Youth Survey

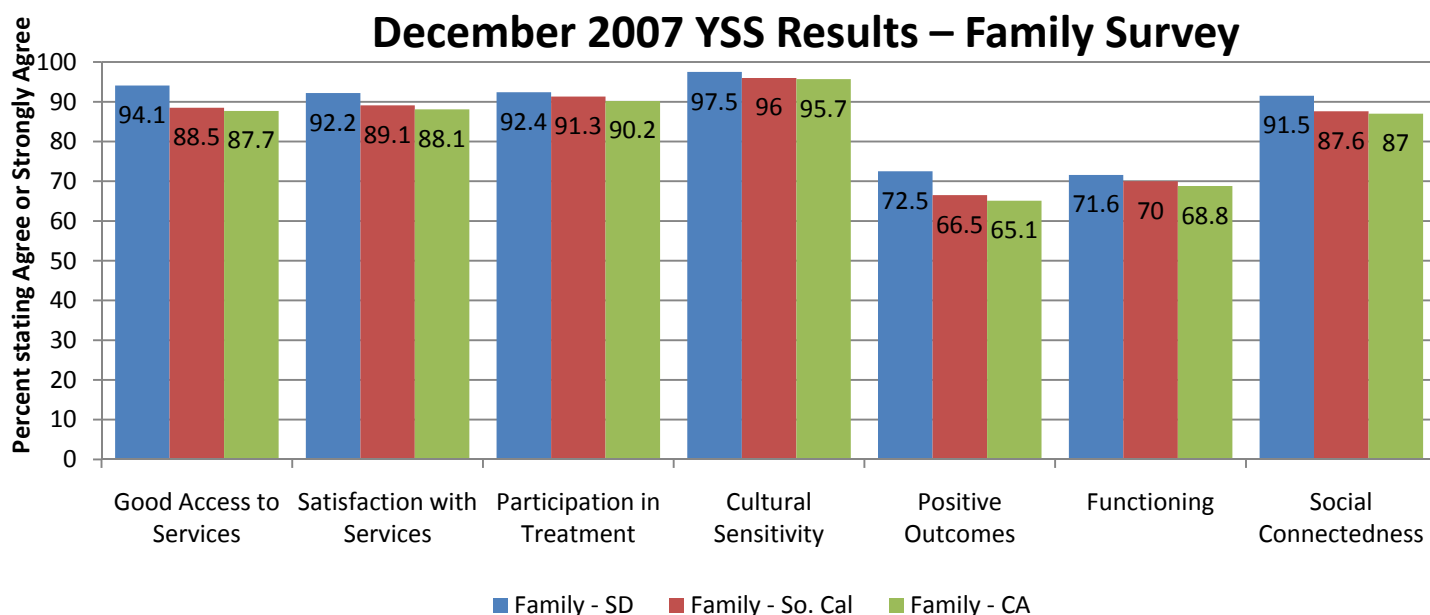
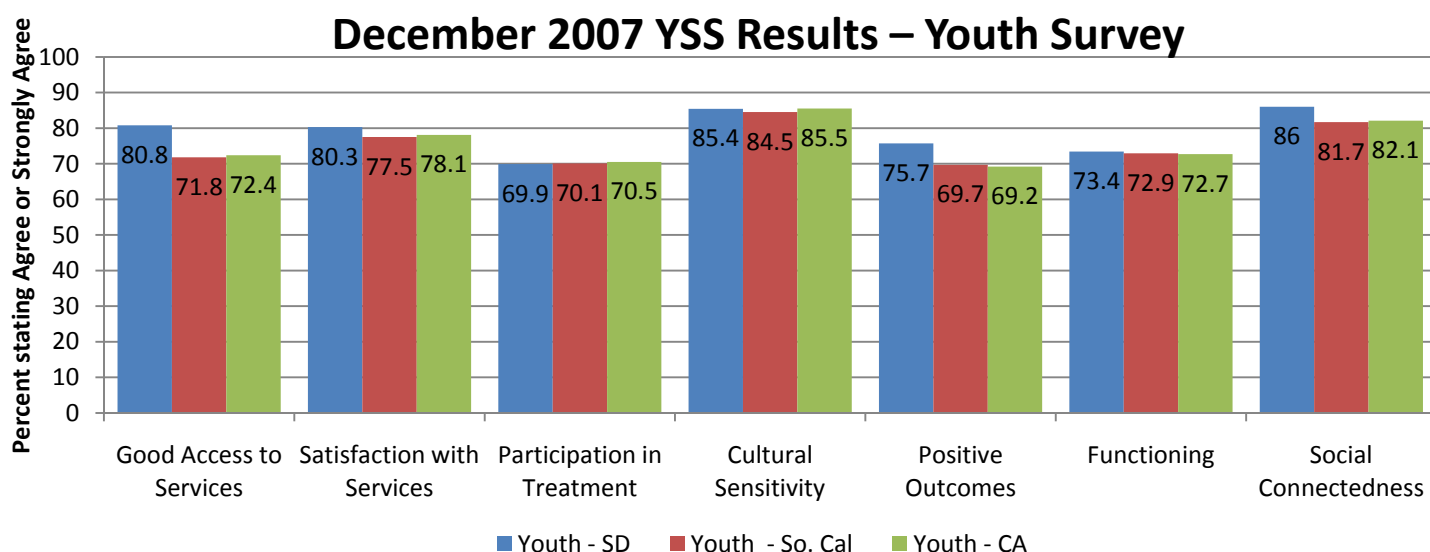


## YSS Responses by Service Modality – Family Survey



Comparison of the San Diego County YSS results with the Statewide and Southern California results show that parents/caregivers in San Diego are **consistently more satisfied with services** than are families in the state as a whole, or in the Southern California region.

The Youth results showed **greater satisfaction on 6 of the 7 domains** among youth in San Diego County, as compared to youth in the Southern California region and California as a whole, on the December 2007 YSS. A similar pattern was also seen in the three years of YSS data. Note: Comparison data is not yet available for the May 2008 YSS.





## Appendices

### Appendix A      Glossary of Terms

Note: Appendices B through H are available electronically or in hard copy from Rose Elwood, CMHS Quality Improvement Office Assistant.

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Appendix B	Service Utilization by Children with Open Child Welfare Cases
Appendix C	Service Use by Youth Receiving Special Education Services
Appendix D	Service Utilization by Children active to the Probation sector
Appendix E	Examination of Primary Diagnosis by Client Characteristics
Appendix F	Detailed Service Utilization Data Tables
Appendix G	Description of Clients by Service Type
Appendix H	CASRC Research News



## Appendix A: Glossary of Terms

- **Assessment** includes intake diagnostic assessments and psychological testing.
- **Case management services** can be provided in conjunction with other services or they can be a stand-alone service that “connects” children, youth and families to the services they need, monitors their care, and oversees the components of care provided to the child and family. “Intensive” case management services are a combination of several modes, with services being focused on the home and family in a “wraparound” model. These services may be short-term or long-term in nature. The goal of these services is to keep children and adolescents in a home setting with services “wrapped” around the home, rather than sending children into residential treatment settings.
- **Collateral services** include family therapy, case consultations, teacher or other professional consultations, attendance at IEP meetings or any other conversations related to the client and treatment plan.
- **Crisis services** include crisis intervention services provided by the programs or at the Emergency Screening Unit.
- **Emergency Screening Unit (ESU)** provides crisis intervention, emergency screening services and crisis stabilization services (up to 24 hours) for children and adolescents throughout the entire county. Services are available 24 hours / 7 days a week.
- **Fee-for-service providers** are primarily licensed **clinicians in private practice** who provide services to clients on a fee-for-service basis. These providers are spread out over the county and represent a diversity of disciplines, cultural-linguistic groups and genders in order to provide choice for eligible clients.
- **Inpatient services** are delivered in hospitals.
- **Intensive day treatment services** are provided in an integrated setting with the child’s education as part of the day. These services are planned and delivered in close coordination with a local education agency. The focus is on psychotherapy interventions.
- **Juvenile Forensic Services** provide services primarily in Probation institutions within the County. Juvenile Forensic Services provides assessment, individual therapy, crisis intervention, consultation, and treatment services to children and adolescents who are involved with the Juvenile Court (both dependents and delinquents). Services are provided throughout the County at sites including Juvenile Hall and Girl's Rehabilitation Facility, Polinsky Children's Center, Juvenile Ranch Facilities, and Camp Barrett.
- **Mean:** Commonly called the average, the mean is the sum of all the scores divided by the number of scores.
- **Median:** The median is the middle of a distribution: half the scores are above the median and half are below the median. The median is less sensitive to extreme scores than the mean and this makes it a better measure than the mean for highly skewed distributions. For example, median income is usually more informative than mean income.
- **Medication services** include medication evaluations and follow-up services.
- **Organizational providers** are community-based agencies and county-operated sites that are either part of the Health & Human Services Agency (HHS) or have contracts with HHS to provide mental health treatment services to specified target populations.
- **Outpatient services** are typically delivered in clinics, institutions, schools and homes.

- **Primary Diagnosis:** Diagnosis was determined by identifying the primary DSM-IV diagnosis at intake from the last episode of service prior to June 30, 2008. Earlier valid diagnoses were chosen when later episodes reported “diagnosis deferred” (799.9) or invalid diagnoses, ones in which there was no valid Title 9 or excluded code provided for any services for that particular client. Excluded diagnoses are those categorized as “excluded” by Title 9 (i.e. autism, learning disabilities). Diagnoses were then grouped into meaningful diagnostic categories according to the Title 9 Medical Necessity Criteria of the California Code of Regulations list of included diagnoses. The Other category includes diagnoses such as Pervasive Developmental Disorder (PDD), Asperger’s Syndrome, Paraphilia, Reactive Attachment Disorder, elimination disorders, and eating disorders. Only one primary diagnosis was indicated per client for these analyses.
- **Rehabilitative day treatment services** are provided in an integrated setting with the child’s education as part of the day. These services are planned and delivered in close coordination with a local education agency. The focus is on skill building and behavioral adjustments.
- **Residential services** are divided in the way they are funded, with Child Welfare providing the funding for “room and board” and Mental Health providing the funding for treatment services through either an outpatient mode or a day treatment mode “patched” on to the “room and board” funding.
- **Therapeutic Behavioral Services (TBS)** include services conducted by paraprofessionals to assist youth in obtaining functional skills in the community, and are provided by programs with a TBS contract.
- **Therapy** includes individual and group therapy.
- **Youth** refers to all children and adolescents (ages 0-17) and young adults (ages 18-25) who received mental health services through CMHS providers.

## Appendix B: Service Utilization by Children with Open Child Welfare Cases

One area of interest to the San Diego County System of Care is the overlap between the mental health and child welfare sectors. It is well documented that children involved in the Child Welfare System (CWS) are an especially vulnerable population with studies estimating that over 40% of these children have significant emotional and behavioral health needs. These children have often experienced long-term abuse and/or neglect, which can have traumatic effects on children and require appropriate treatment.

To examine the Child Welfare – Mental Health overlap in San Diego County, a dataset containing a list of all children who had open Child Welfare cases during FY07-08 was obtained and compared to the CMHS dataset. In FY07-08, 22.5% of youth receiving mental health services also had an open Child Welfare case during the year. Looking at it from the Child Welfare perspective, 28.3% of youth with open Child Welfare cases in FY07-08 also received CMHS services during the year.

**3,961** clients, or **22.5%** of all CMHS clients, were also open to the Child Welfare System in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>	<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	853	21.5%	ADHD:	322	8.9%
6-11:	1207	30.5%	Oppositional / Conduct:	561	15.4%
12-17:	1805	45.6%	Depressive disorders:	521	14.3%
18+:	96	2.4%	Bipolar disorders:	197	5.4%
			Anxiety disorders:	297	8.2%
<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>	Adjustment disorders:	1093	30.0%
Female:	1924	48.6%	Schizophrenic disorders:	10	0.3%
Male:	2037	51.4%	Other:	590	16.2%
Unknown:	0	0.0%	Excluded:	47	1.3%
<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>			
White:	999	25.2%			
Hispanic:	1800	45.4%			
Black:	777	19.6%			
Asian/ PI:	127	3.2%			
Native Am.:	47	1.2%			
Other:	211	5.3%			

**Use of Outpatient Services** – Percent of CMHS-CWS clients using service, Mean Minutes (Median Minutes)

Therapy:	61.6%	1036.0 (680.0)
Collateral:	52.0%	549.9 (190.0)
Crisis Services:	7.6%	407.0 (205.0)
Medication Support:	33.6%	366.9 (185.0)
Case Management / Rehab:	29.7%	1198.1 (280.0)
Assessment:	74.8%	251.6 (180.0)
TBS:	2.5%	5579.0 (5540.0)

**Use of Restrictive Services** – Percent of CMHS-CWS clients using service, Mean Days (Median Days)

Day Treatment:	26.4%	69.8 (26.0)
Crisis Stabilization:	2.4%	1.5 (1.0)
Inpatient:	3.2%	13.2 (7.0)



## Appendix C: Service Use by Youth Receiving Special Education Services

A goal of the San Diego County Children's System of Care is to remove mental health barriers that affect success in school. Children with mental health issues may have difficulties in school, especially if their mental health condition impacts on their school attendance and performance. Many such children become involved in the Special Education system in their local school district, and a large percentage of these children are eligible for special education services under the Emotional Disturbance category.

The **Education definition of Emotional Disturbance (ED)** is as follows: a condition exhibiting one or more of the following characteristics, over a long period of time and to a marked degree, that adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of behavior or feeling under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

A student needs to meet only **one** of the five criteria of the definition of ED to be classified as ED and eligible for special education services.

Using a dataset obtained through the six San Diego County Special Education Local Plan Areas (SELPA) of all children receiving special education services, and identifying a subset receiving services under the ED eligibility category, an examination was made of those children served by CMHS during FY07-08.

**6178** clients, or **35.1%** of all CMHS clients, were also open to Special Education services in FY07-08. **1699** clients, or **9.6%** of all CMHS clients, were open to Special Education services under the Emotional Disturbance (ED) category in FY07-08. Data on both groups are presented below.

	CMHS & Special Education		CMHS & Emotionally Disturbed	
<u>Age:</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
0-5:	374	6.1%	10	0.6%
6-11:	1905	30.8%	325	19.1%
12-17:	3670	59.4%	1271	74.8%
18+:	229	3.7%	93	5.5%
 <u>Gender:</u>	 <u>N</u>	 <u>%</u>	 <u>N</u>	 <u>%</u>
Female:	1725	27.9%	466	27.4%
Male:	4453	72.1%	1233	72.6%
 <u>Race/Ethnicity:</u>	 <u>N</u>	 <u>%</u>	 <u>N</u>	 <u>%</u>
White:	1932	31.3%	712	41.9%
Hispanic:	2786	45.1%	535	31.5%
Black:	1064	17.2%	257	21.0%
Asian/ PI:	127	2.1%	42	2.5%
Native Am.:	42	0.7%	11	0.6%
Other:	226	3.7%	42	2.5%

<b><u>Primary Diagnosis:</u></b>	<b><u>CMHS &amp; Special Education</u></b>		<b><u>CMHS &amp; Emotionally Disturbed</u></b>	
	<b><u>N</u></b>	<b><u>%</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	1251	23.4%	320	20.6%
Oppositional/Conduct:	1143	21.4%	373	24.0%
Depressive:	837	15.6%	291	18.7%
Bipolar:	532	9.9%	304	19.5%
Anxiety:	454	8.5%	129	8.3%
Adjustment:	587	11.0%	34	2.2%
Schizophrenic:	66	1.2%	42	2.7%
Other:	376	7.0%	55	3.5%
Excluded:	103	1.9%	7	0.5%

**Use of Outpatient Services** – Percent of clients using service, Mean Minutes (Median Minutes)

	<b><u>CMHS &amp; Special Education</u></b>		<b><u>CMHS &amp; Emotionally Disturbed</u></b>	
Therapy:	76.1%	962.3 (650.0)	70.3%	1186.2 (785.0)
Collateral:	64.6%	665.0 (300.0)	72.7%	881.8 (375.0)
Crisis Services:	9.1%	334.8 (180.0)	17.0%	407.4 (220.0)
Medication Support:	46.8%	302.7 (175.0)	61.0%	419.0 (250.0)
Case Management / Rehab:	36.3%	1152.6 (300.0)	52.3%	1540.7 (575.0)
Assessment:	58.9%	313.8 (219.0)	58.7%	435.9 (290.0)
TBS:	2.3%	5874.7 (5482.5)	4.2%	5515.1 (4689.0)

**Use of Restrictive Services** – Percent of CMHS-CWS clients using service, Mean Days (Median Days)

Day Treatment:	13.8%	91.2 (72.0)	28.7%	100.3 (84.5)
Crisis Stabilization:	2.8%	1.3 (1.0)	5.8%	1.4 (1.0)
Inpatient:	4.3%	11.9 (7.0)	9.2%	12.9 (8.0)

## Appendix D: Service Utilization by Children active to the Probation sector

To examine the overlap between the Children's Mental Health System and the Probation System in San Diego County, a dataset containing a list of all children who had open Probation cases during FY07-08 was obtained and compared to the CMHS dataset. In FY07-08, 18.2% of youth receiving mental health services also had an open Probation case during the year. Looking at it from the Probation perspective, 41.4% of youth with open Probation cases in FY07-08 also received CMHS services during the year.

**3,212** clients, or **18.2%** of all CMHS clients, were also open to the Probation System in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	0	0.0%
6-11:	10	0.3%
12-17:	2,781	86.6%
18+:	298	9.3%
Unknown	123	3.8%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	647	20.1%
Male:	2,432	75.7%
Unknown:	133	4.1%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	631	19.6%
Hispanic:	1,615	50.3%
Black:	562	17.5%
Asian/ PI:	86	2.7%
Native Am.:	14	0.4%
Other:	304	9.5%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	118	11.0%
Oppositional / Conduct:	413	38.5%
Depressive disorders:	236	22.0%
Bipolar disorders:	123	11.5%
Anxiety disorders:	45	4.2%
Adjustment disorders:	63	5.9%
Schizophrenic disorders:	16	1.5%
Other:	39	3.6%
Excluded:	19	1.8%

**Use of Outpatient Services** – Percent of CMHS-Probation clients using service, Mean Minutes (Median Minutes)

Therapy:	89.3%	493.8 (300)
Collateral:	53.7%	307.7 (95)
Crisis Services:	7.6%	192.6 (60)
Medication Support:	30.3%	196.8 (120)
Case Management / Rehab:	12.5%	1153.1 (150)
Assessment:	21.0%	282.8 (210)
TBS:	0.3%	3944.1 (3540)

**Use of Restrictive Services** – Percent of CMHS-Probation clients using service, Mean Days (Median Days)

Day Treatment:	8.3%	64.7 (49)
Crisis Stabilization:	1.2%	1.3 (1)
Inpatient:	1.5%	9.7 (6)

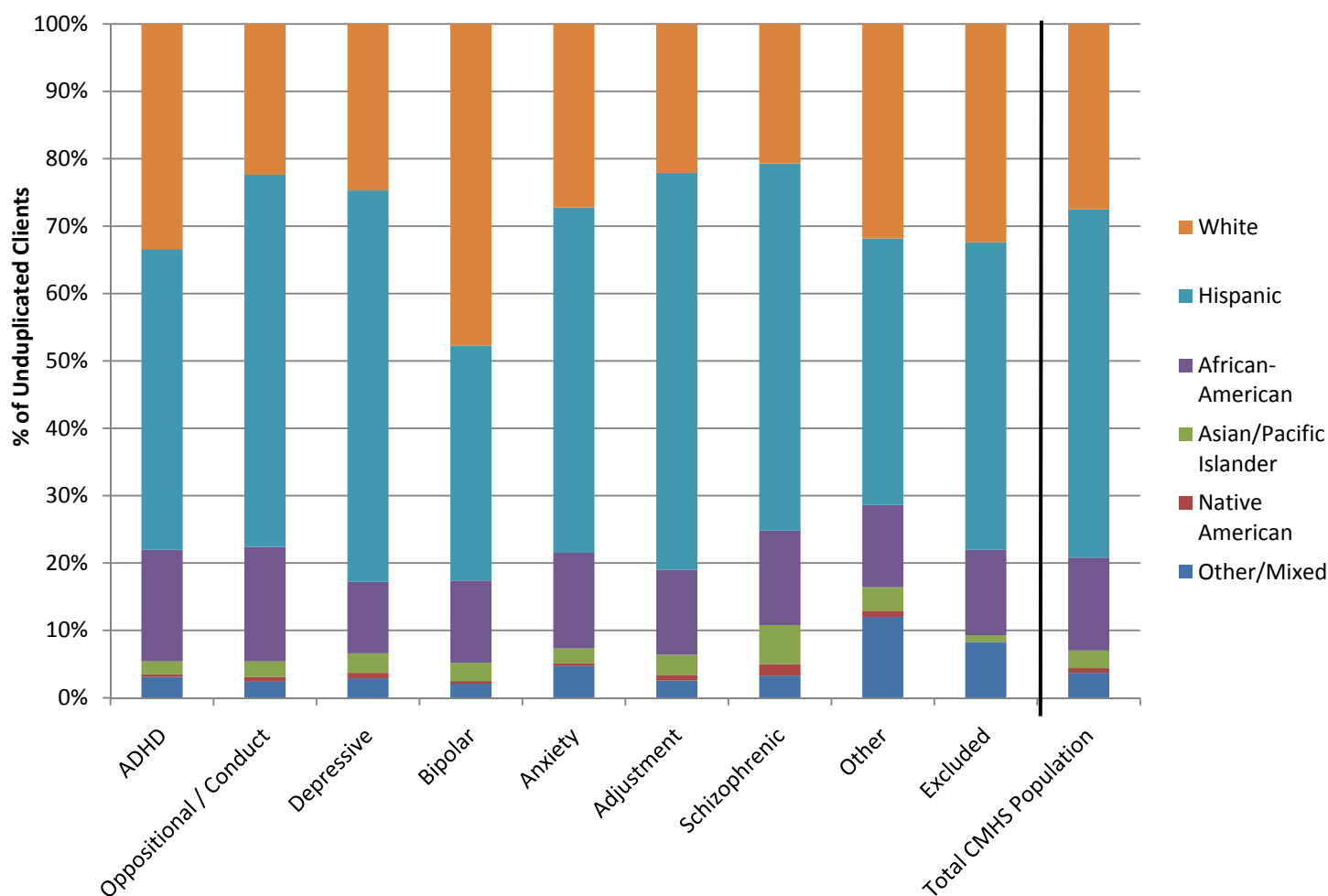


## Appendix E: Examination of Primary Diagnosis by Client Characteristics

The diagnosis categories are examined by race/ethnicity in **Figure E.1**. The racial/ethnic breakdown for the total CMHS sample is displayed on the far right for comparison purposes. There are significant differences in the distribution of diagnoses by racial/ethnic groups, with a large difference seen in the Bipolar disorders: almost 50% of youth diagnosed with Bipolar disorder are White, although White clients compose less than 30% of the total CMHS population. These results are similar to the patterns seen in the past five years, indicating that the distribution is consistent over time.

Although there is limited research on the racial/ethnic differences in the mental health diagnoses of children, several research studies have shown differences in mental health diagnosis along racial / ethnic lines. One of the most consistent findings is that African American youth tend to be more often diagnosed with disruptive behavior disorders.<sup>i</sup> In addition, several studies, including a Veterans Administration study involving over 100,000 veterans, have found that African-Americans are underdiagnosed with Bipolar disorders.<sup>ii</sup>

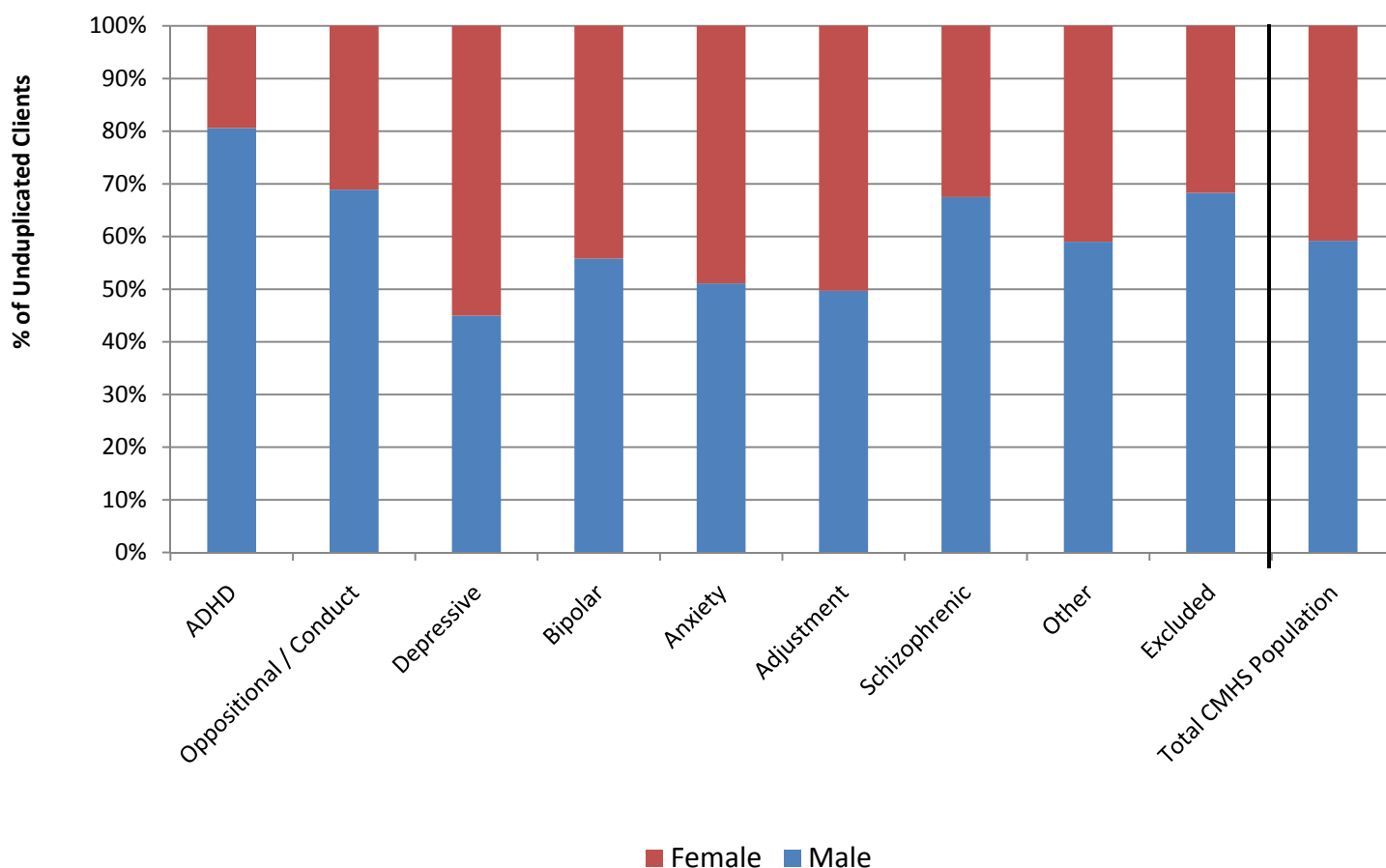
**Figure E.1: Diagnosis by Race/Ethnicity**



The patterns of diagnosis are significantly different by gender. Males are more likely to be diagnosed with externalizing disorders, such as ADHD or Oppositional disorders, while females are more likely to be diagnosed with internalizing disorders, such as depressive or anxiety disorders, as compared to their distribution in the total sample (**Figure E.2**). Again, these results are similar to the patterns over the past five years, indicating that the distribution is consistent over time.

Research has demonstrated some gender differences in the mental health diagnoses of children. ADHD is more likely to be recognized in boys, who tend to exhibit externalizing symptoms (i.e. disruptive behavior), than in girls, who are more likely to exhibit internalizing symptoms (i.e. inattentive behavior),<sup>iii</sup> and gender has been acknowledged as a barrier to appropriate diagnosis in ADHD.<sup>iv</sup> Research has shown that, across cultures, males are more likely to have externalizing problems than females.<sup>v</sup> In addition, depression is more prevalent in women than in men.<sup>vi,vii</sup>

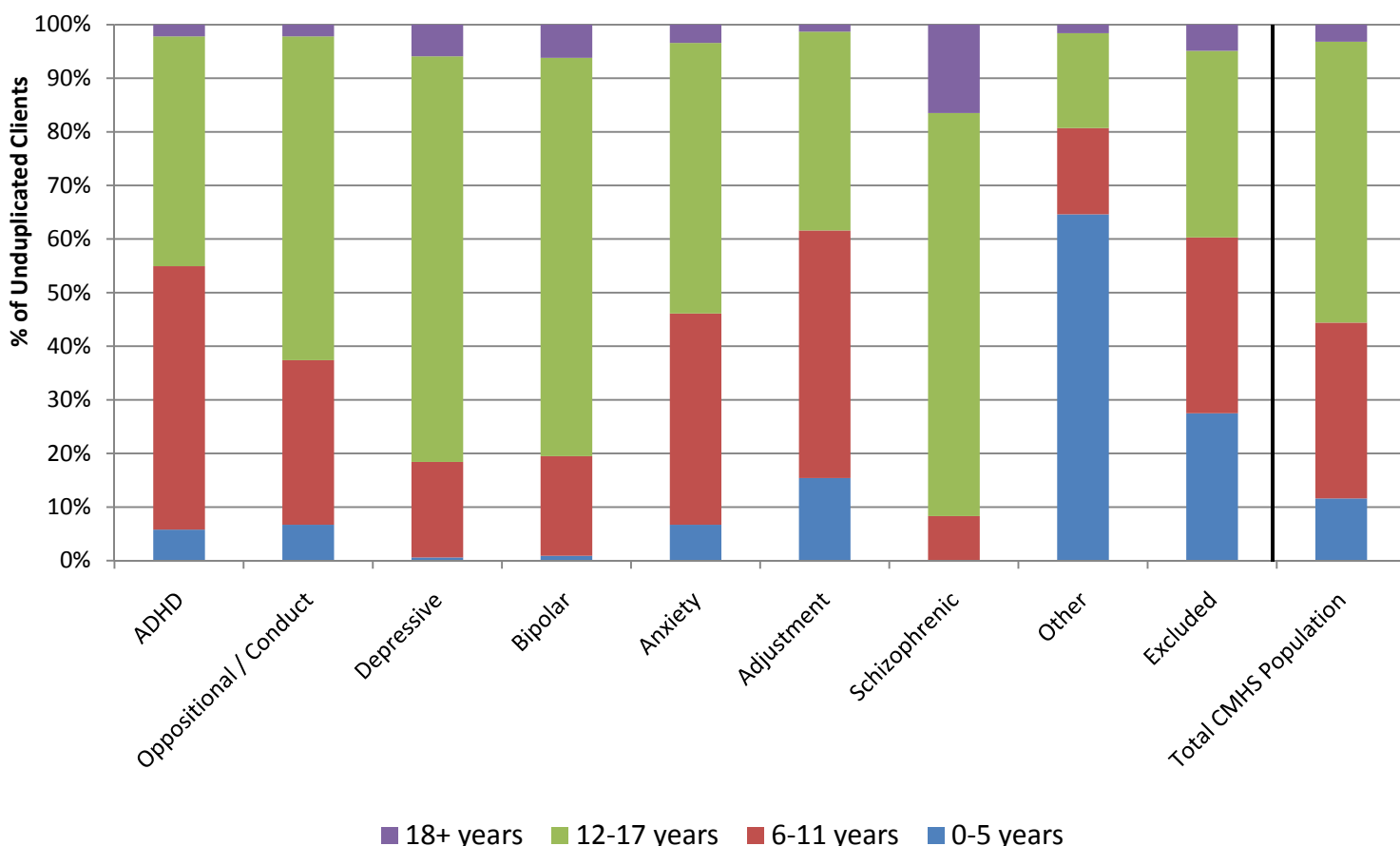
**Figure E.2: Primary Diagnosis by Gender**



When diagnoses are examined by age, significant differences are present (**Figure E.3**). Young children (age 0-5) are being diagnosed with Title 9 excluded diagnoses and diagnoses that fall in the Other category at a markedly higher rate, compared to other age ranges. Elementary age children (age 6-11) are presenting most often with ADHD, anxiety, and adjustment disorders, while schizophrenic, depressive, and bipolar disorders are predominately diagnosed in adolescents. Finally, youth, ages 18 and older, who continue to be served through CMHS are most likely to have a diagnosis of schizophrenia. These patterns are consistent with those found in the previous five years.

These results are also consistent with national data on the onset of mental health disorders. The median age for onset of ADHD is 7 years, while the median age of onset for an anxiety disorder is age 11.<sup>viii</sup> Schizophrenia often first appears in men in their late teens or early twenties, while women are generally affected in their twenties or early thirties.<sup>ix</sup> Symptoms of many mental health disorders begin in childhood and adolescence, resulting in calls for increased prevention and early intervention efforts for children.

**Figure E.3: Primary Diagnosis by Age**



Diagnoses were also examined by **funding source**, which was determined for each client. Medi-Cal status was coded for fee-for-service and organizational providers through service procedure codes. **Overall, 81.8% of youth with a valid diagnosis received Medi-Cal-funded services during the year.** Youth may also receive services through Assembly Bill (AB) 2726, a state-mandated program intended to serve children and youth 3 to 22 years of age receiving special education services who require mental health services in order to benefit from their educational program. AB2726 status was coded if any visit record for the client contained an AB2726 procedure code. **13.2% of youth with a valid diagnosis received services through AB2726 in FY0607.**

Examination of Medi-Cal and AB2726 service use by primary diagnosis shows that there are significant differences: youth in the Bipolar or Schizophrenic categories are less likely to receive services through Medi-Cal funds than other diagnostic groups, and more likely to receive services through AB2726.

In summary, the distribution of diagnoses in the FY07-08 CMHS sample, as well as the relationship of diagnoses with race/ethnicity, gender, and age, is very similar to those found over the past 5 years. This would indicate that the patterns accurately reflect what is occurring in the system and that no major changes in diagnostic patterns occurred over the five year period.

## Appendix F: Detailed Service Utilization Data Tables

**Table F.1: Outpatient Service Utilization by Diagnosis<sup>1</sup>**

Diagnosis	Collateral			Therapy			Case Management			Assessment		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	64.7	550.9	255	73.0	980.8	700	32.3	936.6	205	64.7	263.3	195
ADHD	67.7	668.5	350	81.6	1071.6	804	37.2	1056.6	215	56.7	285.2	200
Oppositional / Conduct	72.6	539.0	247	78.3	948.4	650	36.0	858.1	179	63.4	272.5	210
Depressive	66.1	555.4	260	76.6	978.8	720	34.1	927.5	149.5	57.9	279.5	210
Bipolar	69.8	826.4	335	69.1	1053.8	747.5	47.5	1385.2	455	66.3	361.0	240
Anxiety	66.3	552.6	290	81.4	1019.7	750	28.9	1102.2	190	64.2	282.4	225
Adjustment	67.4	358.5	160	72.8	889.2	627	27.3	594.8	222	70.6	197.5	170
Schizophrenic	62.0	679.1	248	62.0	698.5	400	40.5	1011.6	185	52.9	400.8	232.5
Other	39.5	569.9	340	34.1	1129.2	797.5	13.4	911.6	240	83.4	235.0	180
Excluded	31.9	489.9	240	54.9	729.2	487.5	19.6	523.2	70.5	76.0	265.6	240

Diagnosis	Medication Support			Crisis Services			TBS		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	38.6	257.3	141.5	8.1	304.7	195	1.4	5648.0	5360
ADHD	59.5	239.8	165	4.3	181.9	90	2.0	5614.3	5671
Oppositional / Conduct	42.0	287.1	130	8.9	333.4	205	1.5	5420.1	4407.5
Depressive	39.9	218.8	120	15.7	334.9	230	0.9	5008.5	5139.5
Bipolar	61.0	424.4	230	13.1	346.0	217.5	5.3	6015.7	5645
Anxiety	35.9	227.9	130	5.6	261.5	150	1.3	5247.1	3872
Adjustment	19.6	80.0	50	3.8	203.2	142.5	0.5	6420.1	7037.5
Schizophrenic	61.2	392.8	240	37.2	311.5	215	0.8	11131	11131
Other	16.7	262.7	160	1.6	353.5	160	0.8	5429.6	5540
Excluded	23.5	225.7	142.5	9.3	262.4	170	0.0	---	---

<sup>1</sup>Youth with an invalid or missing diagnosis are excluded from these analyses.

**Table F.2: Restrictive Levels of Service Utilization by Diagnosis<sup>1</sup>**

Diagnosis	Inpatient			Day TX Intensive			Day Rehab			Crisis Stabilization		
	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days
Total Sample	3.6	10.3	6	5.6	97.8	77	7.7	44.2	14	2.5	1.2	1
ADHD	1.0	7.2	6	3.9	117.0	113	4.7	82.2	55.5	0.7	1.3	1
Oppositional/Conduct	3.1	11.5	6	8.0	88.8	62.5	8.9	55.5	21	3.4	1.2	1
Depressive	8.5	9.0	5	4.8	82.1	59	6.4	78.6	44	5.5	1.2	1
Bipolar	9.2	12.1	7	20.4	107.7	97	7.0	67.2	33.5	4.6	1.3	1
Anxiety	1.5	12.7	6	4.0	115.9	111.5	4.4	53.5	20	1.1	1.5	1
Adjustment	0.6	5.7	4	1.8	60.5	44	14.9	12.7	6	0.8	1.0	1
Schizophrenic	28.1	12.1	7.5	13.2	118.1	106.5	5.8	66.4	55	12.4	1.3	1
Other	0.6	22.9	14	3.4	126.0	118.5	1.6	21.3	16.5	0.2	1.5	1.5
Excluded	2.5	5.6	6	3.4	91.4	49	2.9	13.8	10.5	2.9	1.0	1

<sup>1</sup>Youth with an invalid or missing diagnosis are excluded from these analyses.

**Table F.3: Outpatient Service Utilization by Race/Ethnicity<sup>2</sup>**

Race/ Ethnicity	Collateral			Therapy			Case Management			Assessment		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	64.7	550.9	255	73.0	980.8	700	32.3	936.6	205	64.7	263.3	195
White	59.9	576.5	265	73.1	902.7	550	27.2	1062.0	263	56.5	274.0	180
Hispanic	60.7	453.8	195	78.7	797.9	500	26.6	814.9	161	57.2	234.6	180
Black	55.1	484.0	195	75.7	759.2	485	24.4	963.9	243	53.9	247.9	180
Asian/Pacific Islander	57.8	549.3	180	71.0	868.7	580	27.1	1253.6	260	57.1	237.4	180
Native American	52.1	503.6	245	75.6	1020.3	550	34.4	634.3	240	58.8	218.5	152.5
Other/Mixed	27.5	422.8	164	68.8	500.6	250	9.2	970.4	120	55.0	192.0	165

Race/ Ethnicity	Medication Support			Crisis Services			TBS		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	38.6	257.3	141.5	8.1	304.7	195	1.4	5648.1	5360
White	37.0	271.7	150	7.9	247.4	172.5	1.5	5930.4	6109.5
Hispanic	31.8	218.8	120	6.5	280.8	185	0.8	5430.9	5295
Black	38.6	261.5	135	9.0	300.5	140	1.8	5489.4	4527.5
Asian/Pacific Islander	28.8	244.1	140	9.4	321.1	180	1.1	5851.8	6871
Native American	32.8	303.0	180	9.2	285.5	235	0.8	10780.0	10780
Other/Mixed	17.5	171.7	90	2.1	350.3	150	0.1	3004.0	3004

<sup>2</sup>Youth with a missing race/ethnicity code are excluded from these analyses.

**Table F.4: Restrictive Service Utilization by Race/Ethnicity<sup>2</sup>**

Race/ Ethnicity	Inpatient			Day TX Int.			Day Rehab			Crisis Stabilization		
	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days
Total Sample	3.4	10.3	6	5.3	97.8	77	7.2	44.2	14	2.4	1.2	1
White	3.5	9.4	7	6.5	101.3	84	5.6	54.6	20	2.1	1.1	1
Hispanic	2.5	10.2	5.5	3.0	87.4	68	5.0	40.2	12	1.9	1.2	1
Black	2.9	11.3	7	6.6	108.2	84	10.4	42.7	14	2.4	1.2	1
Asian/Pacific Islander	3.6	15.9	6	3.6	94.5	97	10.0	31.9	8	3.2	1.4	1
Native American	4.2	5.8	5	5.0	123.5	132.5	7.6	40.3	5	2.5	1.0	1
Other/Mixed	1.2	12.0	5	1.3	80.0	29	2.4	51.9	24	0.4	2.0	1.5

<sup>2</sup> Youth with a missing race/ethnicity code are excluded from these analyses.



## Appendix G: Description of Clients by Service Type

### Clients Utilizing Outpatient Services

**9222** unique clients, or **52.4%** of all clients, used services from an outpatient Clinic- or School-based organizational provider in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	1330	14.4%
6-11:	3115	33.8%
12-17:	4510	48.9%
18+:	267	2.9%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	3667	39.8%
Male:	5508	59.7%
Unknown:	47	0.5%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	2179	23.6%
Hispanic:	5332	57.8%
Black:	1105	12.0%
Asian/ PI:	248	2.7%
Native Am.:	60	0.7%
Other:	298	3.2%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	1442	15.7%
Oppositional / Conduct:	1936	21.1%
Depressive disorders:	1650	18.0%
Bipolar disorders:	543	5.9%
Anxiety disorders:	720	7.9%
Adjustment disorders:	1779	19.4%
Schizophrenic disorders:	64	0.7%
Other:	933	10.2%
Excluded:	99	1.1%

#### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	77.7%	1068.8 (775.0)
Collateral:	79.2%	533.7 (255.0)
Crisis Services:	7.4%	304.2 (180.0)
Medication Support:	43.1%	244.3 (145.0)
Case Management / Rehab:	36.3%	852.3 (180.0)
Assessment:	72.6%	269.7 (200.0)
TBS:	1.3%	5180.8 (4723.0)

#### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	9.8%	45.0 (18.0)
Crisis Stabilization:	1.9%	1.3 (1.0)
Inpatient:	3.2%	10.8 (6.0)

## Clients Utilizing Case Management Services

**1968** unique clients, or **11.2%** of all clients, used services from an organizational case management provider in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	31	1.6%
6-11:	584	29.7%
12-17:	1296	65.9%
18+:	57	2.9%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	703	35.7%
Male:	1256	63.8%
Unknown:	9	0.5%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	812	41.3%
Hispanic:	760	38.6%
Black:	283	14.4%
Asian/ PI:	51	2.6%
Native Am.:	20	1.0%
Other:	42	2.1%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	359	19.4%
Oppositional / Conduct:	370	20.0%
Depressive disorders:	344	18.6%
Bipolar disorders:	302	16.4%
Anxiety disorders:	163	8.8%
Adjustment disorders:	174	9.4%
Schizophrenic disorders:	30	1.6%
Other:	84	4.5%
Excluded:	21	1.1%

### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	60.5%	1180.3 (900.0)
Collateral:	75.2%	1264.7 (519.5)
Crisis Services:	12.3%	344.2 (195.0)
Medication Support:	49.6%	389.4 (250.0)
Case Management / Rehab:	86.3%	1704.1 (611.0)
Assessment:	85.1%	505.9 (432.0)
TBS:	4.4%	5653.3 (4969.0)

### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	24.4%	85.5 (59.0)
Crisis Stabilization:	3.9%	1.4 (1.0)
Inpatient:	7.3%	12.5 (7.0)

## Clients Utilizing Wraparound Services

**524** unique clients, or **3.0%** of all clients, used services from an organizational wraparound services provider in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	5	1.0%
6-11:	134	25.6%
12-17:	372	71.0%
18+:	13	2.5%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	202	38.5%
Male:	320	61.1%
Unknown:	0	0.4%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	181	34.5%
Hispanic:	230	43.9%
Black:	87	16.6%
Asian/ PI:	14	2.7%
Native Am.:	1	0.2%
Other:	11	2.1%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	103	19.7%
Oppositional / Conduct:	131	25.0%
Depressive disorders:	114	21.8%
Bipolar disorders:	89	17.0%
Anxiety disorders:	37	7.1%
Adjustment disorders:	31	5.9%
Schizophrenic disorders:	8	1.5%
Other:	8	1.5%
Excluded:	3	0.6%

### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	76.0%	1245.5 (1022.5)
Collateral:	96.1%	2754.8 (2083.0)
Crisis Services:	19.7%	366.9 (190.0)
Medication Support:	73.9%	457.8 (295.0)
Case Management / Rehab:	96.0%	3830.4 (2680.0)
Assessment:	80.2%	574.2 (491.5)
TBS:	9.5%	5708.8 (5535.0)

### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	34.9%	100.4 (79.0)
Crisis Stabilization:	6.5%	1.5 (1.0)
Inpatient:	12.0%	14.2 (8.0)

## Clients Utilizing Day Treatment Services

**1841** unique clients, or **10.5%** of all clients, used services from a Day Treatment provider in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	109	5.9%
6-11:	426	23.1%
12-17:	1226	66.6%
18+:	80	4.3%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	770	41.8%
Male:	1064	57.8%
Unknown:	7	0.4%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	591	32.1%
Hispanic:	732	39.8%
Black:	397	21.6%
Asian/ PI:	67	3.6%
Native Am.:	15	0.8%
Other:	39	2.1%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	199	10.8%
Oppositional / Conduct:	420	22.9%
Depressive disorders:	304	16.5%
Bipolar disorders:	222	12.1%
Anxiety disorders:	131	7.1%
Adjustment disorders:	463	25.2%
Schizophrenic disorders:	21	1.1%
Other:	67	3.6%
Excluded:	11	0.6%

### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	51.8%	921.4 (662.5)
Collateral:	67.1%	559.9 (90.0)
Crisis Services:	13.4%	470.7 (205.0)
Medication Support:	59.4%	531.9 (340.0)
Case Management / Rehab:	35.8%	1586.5 (625.0)
Assessment:	67.8%	335.7 (240.0)
TBS:	4.2%	5704.9 (4911.5)

### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	88.8%	71.3 (38.0)
Crisis Stabilization:	5.2%	1.6 (1.0)
Inpatient:	7.3%	14.9 (9.0)

## Clients Utilizing Inpatient Services

**492** unique clients, or **2.8%** of all clients, used services from an Inpatient provider in FY07-08.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	7	1.4%
6-11:	82	16.7%
12-17:	391	79.5%
18+:	12	2.4%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	261	53.0%
Male:	221	44.9%
Unknown:	10	2.0%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	160	32.5%
Hispanic:	226	45.9%
Black:	73	14.8%
Asian/ PI:	17	3.5%
Native Am.:	5	1.0%
Other:	11	2.2%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	22	4.5%
Oppositional / Conduct:	84	17.1%
Depressive disorders:	221	44.9%
Bipolar disorders:	84	17.1%
Anxiety disorders:	18	3.7%
Adjustment disorders:	17	3.5%
Schizophrenic disorders:	34	6.9%
Other:	7	1.4%
Excluded:	5	1.0%

### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	68.3%	1084.0 (743.5)
Collateral:	64.0%	1040.7 (450.0)
Crisis Services:	62.2%	518.1 (302.5)
Medication Support:	65.7%	517.2 (310.0)
Case Management / Rehab:	50.0%	1651.8 (520.0)
Assessment:	66.5%	428.5 (293.0)
TBS:	10.2%	6022.9 (6181.0)

### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	27.0%	99.4 (84.0)
Crisis Stabilization:	38.8%	1.4 (1.0)
Inpatient:	100%	10.3 (6.0)

While most children had only one inpatient stay, **21.7% of the inpatient sample had two or more episodes of care in the inpatient setting** in FY07-08 (the number of episodes ranged from 1 to 10 during FY07-08). This is especially concerning given that **69.2%** of children with two or more inpatient episodes were **readmitted to the hospital within 30 days** of the previous discharge.

## Youth active to both CMHS and ADS sectors

The characteristics of youth who were active to both the CMHS and ADS sectors were examined using a dataset obtained from ADS that listed all clients served during FY07-08. Being active to both sectors is an indication that they have both mental health and substance use needs serious enough to warrant treatment. Overall, **519 youth receiving CMHS services (2.9%) were also active to ADS** during the fiscal year.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	0	0.0%
6-11:	0	0.0%
12-17:	519	100.0%
18+:	0	0.0%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	135	26.0%
Male:	384	74.0%
Unknown:	0	0.0%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	117	22.6%
Hispanic:	295	56.9%
Black:	71	13.7%
Asian/ PI:	8	1.5%
Native Am.:	1	0.2%
Other:	26	5.0%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	25	9.5%
Oppositional / Conduct:	90	34.1%
Depressive disorders:	72	27.3%
Bipolar disorders:	24	9.1%
Anxiety disorders:	15	5.7%
Adjustment disorders:	18	6.8%
Schizophrenic disorders:	5	1.9%
Other:	2	0.8%
Excluded:	13	4.9%

### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	90.9%	595.9 (372.5)
Collateral:	59.5%	408.3 (135.0)
Crisis Services:	8.1%	276.1 (150.0)
Medication Support:	36.0%	220.5 (130.0)
Case Management / Rehab:	18.3%	949.0 (94.0)
Assessment:	34.1%	270.8 (210.0)
TBS:	0.4%	4030.5 (4030.5)

### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	11.2%	51.8 (31.5)
Crisis Stabilization:	2.3%	1.0 (1.0)
Inpatient:	3.3%	7.1 (5.0)

## Youth with a Dual Diagnosis

**273** youth who received CMHS services in FY07-08 (**1.6%** of total CMHS population) had a secondary substance abuse diagnosis entered in INSYST.

<b><u>Age:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
0-5:	0	0.0%
6-11:	1	0.4%
12-17:	240	87.9%
18+:	32	11.7%

<b><u>Gender:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
Female:	110	40.3%
Male:	163	59.7%
Unknown:	0	0.0%

<b><u>Race/Ethnicity:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
White:	95	34.8%
Hispanic:	135	49.5%
Black:	26	9.5%
Asian/ PI:	11	4.0%
Native Am.:	1	0.4%
Other:	5	1.8%

<b><u>Primary Diagnosis:</u></b>	<b><u>N</u></b>	<b><u>%</u></b>
ADHD:	14	5.1%
Oppositional / Conduct:	87	31.9%
Depressive disorders:	69	25.3%
Bipolar disorders:	35	12.8%
Anxiety disorders:	9	3.3%
Adjustment disorders:	18	6.6%
Schizophrenic disorders:	2	0.7%
Other:	0	0.0%
Excluded:	39	14.3%

### **Use of Outpatient Services** – Percent of Outpatient clients using service, Mean Minutes (Median Minutes)

Therapy:	68.9%	763.5 (500.0)
Collateral:	74.0%	490.2 (232.5)
Crisis Services:	16.8%	392.8 (262.5)
Medication Support:	49.1%	234.0 (126.5)
Case Management / Rehab:	42.9%	788.4 (100.0)
Assessment:	66.3%	281.3 (210.0)
TBS:	0.7%	1390.0 (2390.0)

### **Use of Restrictive Services** – Percent of Outpatient clients using service, Mean Days (Median Days)

Day Treatment:	23.4%	54.9 (20.0)
Crisis Stabilization:	9.2%	1.1 (1.0)
Inpatient:	6.6%	5.3 (5.0)



## Appendix H: CASRC Research News

The System of Care Evaluation (SOCE) is conducted through the Child and Adolescent Services Research Center (CASRC) at Rady Children's Hospital-San Diego. CASRC is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County, including Rady Children's Hospital, University of California at San Diego, San Diego State University, University of San Diego, and California State University, San Marcos. The Investigators conducting research at CASRC are awarded funding from a variety of sources, ranging from the largest government based institutions (NIH) to county level agencies. While a wide variety of studies are routinely being conducted at CASRC, all research at the Center shares the same focus of improvement of public pediatric mental health care through a program of mental health services research. An overarching center perspective of cultural exchange guides an active partnership with major stakeholders in youth mental health care across the public sectors of mental health, child welfare, juvenile justice, substance abuse services, and education.

Investigators at CASRC believe in using collaborative methods to conduct community-based research with stakeholder groups. Part of this process involves routinely sharing the results of studies with participants to include clinicians, youth and families and administrators. A summary of activities conducted on six of the largest studies during FY07-08 that are relevant to public children's mental health services are presented here.

### **Practice and Research: Advancing Collaboration (PRAC)**

Principal Investigator: Ann Garland, Ph.D.

Funding: National Institute of Mental Health

Very little is known about the psychotherapeutic approaches that are used most often in community-based clinics because there has been minimal research on community-based practice. In contrast, there has been a great deal of research identifying specific psychotherapeutic approaches that demonstrate efficacy (labeled evidence-based practices), but we don't know enough about how, if at all, these approaches are being delivered in community-based care. The PRAC study is the first study in the country to rigorously examine community-based psychotherapy practice for children, ages 4-13, who presented with disruptive behavior problems (DBPs, including aggressive, delinquent, oppositional and defiant behaviors).

PRAC is an observational study of psychotherapy, i.e., there was no intervention or manipulation of treatment. The specific aims were to:

- (1) Identify the consistencies and inconsistencies between evidence-based principles of care and practitioners' perceptions of effective treatment for youth disruptive behavior problems;
- (2) Examine the extent to which actual practice in community out-patient clinics is consistent with evidence-based principles and practitioner-based principles;
- (3) Examine how practice consistent and inconsistent with these principles is associated with changes in child and family outcomes in community out-patient care, and
- (4) Explore how the links between practice and outcomes are moderated by child, parent and family characteristics such as race/ethnicity, parental psychopathology and parental attitudes and stress.

Data collection for this study concluded in June, 2008; data analyses and interpretation are currently underway. Participants in the study included 218 children and their families and 100 psychotherapists (MFT's, SW's, and Psychologists) recruited from six outpatient clinics in San Diego County. Over 3,200 therapy sessions were videotaped and a random sample of 1,215 was coded to characterize the treatment strategies therapists might use in psychotherapy sessions with children and/or parents. PRAC also interviewed children, parents, and clinicians to collect additional data on therapy processes such as therapeutic alliance and treatment outcomes, including changes in symptom severity, family functioning, satisfaction, and parenting practices.

Preliminary findings: It should be noted that while preliminary findings are outlined below, analyses are still being conducted and thus there may be some revisions or additions to these findings that emerge with different analytic approaches.

- 1) Therapists were rated highly on warmth and empathy by videotape observers. Likewise, almost all children, parents and clinicians rated the quality of the therapeutic alliance positively.
- 2) The psychotherapy approaches reflected great breadth, but not great depth. Specifically, therapists were observed using many different therapeutic strategies within and across treatment sessions targeting children and their caregivers, but the average intensity of these strategies was low (2.3 on a 1-6 scale). Fewer than 10% of all coded sessions included any treatment strategy observed at high intensity.
- 3) Some of the therapeutic strategies common in evidence-based (EB) treatments for this population were observed in a majority of sessions (e.g., positive reinforcement for children, psycho-education for caregivers), but they were not observed at the same intensity as would be expected for an EB protocol.
- 4) Other strategies common in EB practice were observed only rarely (i.e., <25% of sessions) at any intensity. These include more directive, active skill-building techniques such as role-playing/rehearsal, modeling, and assigning/reviewing homework tasks.
- 5) The most frequently observed treatment strategy with children and adults was “assessing problems and events,” which included general clarification of events and supportive listening. The most commonly observed treatment content addressed with parents was case management.
- 6) There was great variability in amount of care received; the mean number of sessions attended over 16 months was 21, but the range was 0 – 63. The majority of children received many additional services, including medication (62%) and school-based care (88%); 9% were hospitalized or placed in residential treatment for psychiatric reasons during the 16 months they were followed.
- 7) Child clinical characteristics (e.g., primary diagnosis, baseline symptom severity) and demographic characteristics (e.g., age, gender, race/ethnicity) were not strongly related to the amount or type of treatment observed.
- 8) There were few therapist characteristics associated with specific treatment practices. Therapist experience and discipline (psychology, social work, MFT) were generally unrelated to the observed intensity of treatment strategies and/or use of EBP strategies.
- 9) Outcome data indicate that, on average, participants exhibited modest improvement in child symptom severity and family functioning, particularly within the first 4 months of the study period. Current analyses are attempting to identify child/family, therapist, or treatment characteristics associated with outcomes, but to date few significant predictors of outcomes have been identified.

Summary: This study offers a rare glimpse inside therapists' offices in publicly-funded psychotherapy. Not surprisingly, therapists were observed to be very supportive and empathic. However, therapists were not often observed delivering the types of active, directive intervention strategies which are common in EB treatment for this population (e.g., behavioral rehearsal/role playing, problem-solving skill building, assigning/reviewing homework). Outcome data revealed modest average improvements for the majority of the children, but it appears that improvement was not necessarily associated with amount of treatment. In addition, while the therapists came from different training backgrounds, there were relatively few differences in observed practice associated with therapist characteristics. In follow-up discussions reviewing findings and planning future studies with our practice collaborators, they confirm our qualitative impression of the dominant “culture” within these clinics; this culture values supportive, relatively non-directive treatment approaches, with relationship-building of paramount importance. Thus, therapists readily employ supportive listening and empathy skills, yet many are ambivalent about utilizing more active, directive, skill-building therapeutic strategies, such as those common in many EB treatments. This complements our data from parent and youth consumers evaluating therapists as very supportive, but not necessarily solution-focused.

Ongoing Activities: This study continues to attract local and national attention as a rare effort to gather systematic data about “usual care” psychotherapy practice. Dr. Garland has been invited to speak about this study at many conferences of psychotherapy research and related topics, as well as many state and local forums. In an effort to disseminate the results of the study locally to community participants, a half-day “Collaborative Expo” was organized and facilitated through a collaborative effort by the research team and clinical advisors in June, 2008. During this interactive educational event, researchers and clinicians jointly presented on a variety of topics of interest including results from the PRAC project, Autism Spectrum Disorders, Difficult Cases, and Parents’ engagement in children’s care. Cross-cultural considerations were discussed for all topics.

Publications: Manuscript preparation is in progress on specific topics, including characterization of treatment processes in usual care and the extent to which they are consistent with evidence-based practice, case management as a component of usual care, and therapists’ attitudes towards psychotherapeutic strategies.

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## **Mixed-Methods Study of a Statewide EBP Implementation**

Principal Investigator: Gregory A. Aarons, Ph.D.

Funding: National Institute of Mental Health

The implementation of evidence-based practice (EBP) into real-world human service settings is an important priority for improving the quality of services and outcomes for families. However, little is known about what factors facilitate or impede implementation, and how implementation of an EBP affects organizations and staff. The goal of this project is to study the effects of an Oklahoma statewide implementation of SafeCare, an evidence-based intervention designed to reduce child abuse and neglect. The specific aims of this project are to examine contextual and individual factors associated with EBP implementation fidelity, the effect of EBP implementation on perceived job autonomy, turnover intentions, and job turnover, and the effect of EBP implementation on organizational climate, working alliance, and client outcomes using both quantitative and qualitative research methods.

**Progress:** The 6<sup>th</sup> and 7<sup>th</sup> waves of quantitative data collection were completed. 253 web-based surveys were completed by public sector mental health service case managers and supervisors, the response rate ranging from 96.2% to 98.4%. Second, an annual meeting of investigators, consultants, and agency representatives convened. The group jointly reviewed qualitative and quantitative data, triangulating on findings and using both sets of data for contextualizing and interpretation of the data.

## **Family Recovery Center Evaluation**

Principal Investigator: Gregory A. Aarons, Ph.D.

Funding: SAMHSA

Mental Health Services, Inc received funding under the SAMHSA Residential Treatment for Pregnant and Postpartum Women to expand and enhance comprehensive, residential substance abuse treatment program for low-income pregnant, postpartum and parenting women and their minor children, age 10 and under, who have limited access to quality health services and/or may be members of underserved populations. To strengthen their services, MHS' Family Recovery Center (FRC) added a new evidence-based intervention, the Incredible Years, an intervention focused on strengthening parenting competencies (monitoring, positive discipline, confidence) and fostering parents' involvement in children's school experiences in order to promote children's academic, social and emotional competencies and reduce conduct problems. FRC has partnered with Dr. Aarons as an independent evaluator to monitor the effects of the services added with this funding.

**Progress:** 43 adult female clients and 38 of their children were enrolled in the evaluation. Each client completes an interview at intake, 6 months post-intake, discharge, and 6 months post-discharge. The study has had an overall retention rate of 82.4% from intake to 6-months post-intake. The overall median number of days in treatment is 149. The study has found improvements in abstinence from alcohol and/or drugs, abstinence from risky sexual behavior, arrest rate, employment and school enrollment. Clients reported a significant decrease in symptoms of depression/anxiety, difficulty with relationships, and difficulty with daily living from intake to 6 months post-intake.

## **Enhancing Autism Intervention in Mental Health Services (AIM)**

Principal Investigator: Lauren Brookman-Frazee, Ph.D.

Funding: National Institute of Mental Health

The goal of the AIM study is to improve mental health services for children with Autistic Spectrum Disorders (ASD) by using data on usual care to develop and test a MH intervention approach that integrates research-based behavioral and cognitive behavioral treatment methods into community-based practice. Qualitative and quantitative data were gathered from providers and consumers to identify the clinical needs of the children with ASD and the training needs of providers in order to develop an intervention approach that is tailored for this community context.

Progress: Information on the clinical needs of children with ASD being served in community-based outpatient psychotherapy were collected through secondary analyses of the PRAC study (PI: A. Garland) of a sub-sample of 19 children with ASD and a matched non-ASD comparison group. Further, 21 semi-structured interviews were conducted with parents of children with an ASD. A number of themes emerged:

- 1) Most children involved in this system had high functioning ASD diagnoses, were diagnostically complex, and presented with externalizing behaviors.
- 2) Access to MH services was often funded through the educational system following severe behavioral escalation.
- 3) Psychotherapy process and outcome was similar for children with and without ASD and parents viewed limited number of MH providers with ASD training as a significant barrier to accessing effective care.

Data on provider training needs related to serving children with ASD were collected through a survey of 100 clinicians in 9 outpatient MH clinics and 3 follow up focus groups with 17 clinicians aimed to confirm, complement, and expand information collected through the survey. A number of themes emerged:

- 1) Therapists frequently provide psychotherapy to children with high functioning ASD with complex service needs (76.0% of survey respondents have provided psychotherapy to a child with ASD and they represent an average of 20.7% of therapists' *current* caseloads).
- 2) Therapists identify a number of challenges associated with working with these children and experience frustration serving them (e.g., slow progress, coordination of care/ system issues, lack of client insight).
- 3) Therapists have limited ASD training and are highly motivated for additional training (98% of clinicians surveyed indicated that they would likely attend training and a majority endorsed behavior and social skills problems as the most useful topics for trainings).
- 4) Therapists desire comprehensive ASD training, including information on differential diagnosis and common characteristics of ASD, treatment planning (guidance on identifying realistic goals and tracking progress towards these goals), modifications to psychotherapy (how to adapt therapy content and structure for clients with ASD), intervention strategies (strategies for both children and for their parents); coordination of care (information about other community services).

## **Cognitive Consensus in Cross-Cultural Competence (TWIST)**

Principal Investigator: May Yeh, Ph.D.

Funding: National Institute of Mental Health

The Cognitive Consensus in Cross-Cultural Competence study is known as “TWIST” (Team Work in Services for Teens) in the community. The study examines teamwork related factors at treatment entry and their relationship to treatment outcomes, with a special interest in how such factors may be important to issues of cultural competence. We are very pleased to have an excellent working relationship with the agencies, therapists, and families associated with our study, and we are highly appreciative of their partnership and support of this project.

Agencies and therapists who provide clinic- or school-based outpatient mental health services to youth aged 12-18 were asked if they would like to participate in the study. Upon receipt of signed informed consent/assent from adolescents who were beginning psychotherapy with participating therapists, interviews were conducted with youth, parents and therapists. Follow-up interviews via telephone take place at 2, 4, 6, and 12 months after the baseline interview with the youth and parents, and with the therapist until services are terminated.

Progress: Project activities have focused upon subject recruitment and data collection to complete our second year in the field. We currently have 91 therapists participating, and recruitment is continuing. Additionally, we have completed baseline interviews with 214 youths/parents. Of this sample, 57.9% are male and 42.1% are female. Additionally, 69.2% are Hispanic, 18.7% are African American, 7.0% are White, 2.8% are Asian and 0.9% are American Indian/Alaskan Native. While we have currently recruited a diverse sample of adolescent participants, we are having difficulty recruiting Asian American participants. We have sought feedback from our participants through a survey at the 2 month follow-up point, inquiring if they would recommend participation in the study to others. Our recommendation rates are extremely high. Of the 100 therapist surveys completed (therapists could complete the survey more than once if they had more than one family in the study), 99 (99%) of the responses indicated that, “yes,” therapists would recommend TWIST to their colleagues, with 1 (1%) saying, “maybe,” and none (0%) answering, “no.” Their reasons for participating in the project include: “It’s a really good opportunity to participate in a longitudinal study looking at various ways to help a family. Helping clients and the TWIST study will help families overall,” “It is really easy and fun to do,” and “Research is very important for improving the field...Plus the study is very easy!”. Of the 106 parents asked if they would recommend the study, 103 (97.2%) parents responded “Yes”, 3 (2.8%) responded “Maybe” and 0 (0%) responded “No” (total n=106). Of the 104 youths assessed, 79 (76%) responded “Yes”, 16 (15.4%) responded “Maybe” and 9 (8.7%) responded “No”. We were extremely pleased with these high numbers of recommendation, given that these are likely families in distress and persons who may be experiencing multiple demands upon their time.

Ongoing Activities: Plans for the coming year include continued subject recruitment (therapists, parents, adolescents), data collection, collaboration with community partners and consultation with experts. We will also continue communicating with program managers and therapists from both the schools and clinics in person and through e-mail, to facilitate participation in a manner that is easiest for our participants. We anticipate ending our recruitment June 2009, however, we anticipate that follow-ups will continue for one year following the final baseline interview.

Eventual analyses from the study will focus upon teamwork between the youth, parent, and therapist in services, and how this may relate to the progress of treatment. Specifically, the study analyses will include describing the treatment entry factors that are associated with youth, parent, and therapist agreement upon various aspects of treatment, and whether agreement upon various treatment issues is associated with premature drop-out, service use, and treatment outcomes.

## **Parent and Family Factors in Child Mental Health**

Principal Investigator: Mary Baker, Ph.D.

Funding: National Institute of Mental Health

Quantitative and qualitative studies were conducted within public-funded outpatient psychotherapy clinics for children receiving services for problem behaviors examining parent and family factors.

Progress: Two hundred and seventeen families completed assessment measures on parent issues (psychopathology, depression, stress, competence, substance use, strain) and family issues (domestic violence, family relations, couple relations, social support, family empowerment). Additionally, twenty-six therapists, fourteen parents and ten youth participated in focus groups and semi-structured interviews discussing their perspectives of which parent and family factors impact child treatment and experiences and satisfaction with their child's treatment.

### Preliminary Findings:

#### **Prevalence of Parent and Family Factors**

<b>Parent Factors n=217</b>	<b>Family Factors n=217</b>
Psychopathology= 43%	Domestic Violence current= 14%; History= 50%
Depression= 41%	Family Relationship Problems= 52%
Clinical levels of stress= 72%	Couple Relationship Problems= 11%
Low level of parenting competence= 14%	Low levels of social support= 50%
Substance use= Alcohol= 22%; Drug= 11%	

Results from the qualitative study indicate that therapists and parents alike view a large number of parent and family factors as relevant and impacting outpatient mental health services for children with disruptive behavior problems. Participants generated 17 factors that were not studied previously in research samples highlighting the value of learning about community mental health services from individuals involved in the services. Other notable findings were that parents are clearly willing to discuss their own issues with their children's therapists and that parents view their own personal and family issues as directly relevant to their child's problems and treatment. Overall, however, parents do not feel supported within the child service system and often feel blamed for their children's problems.

Another important finding is the apparent disconnect between parents and therapists regarding treatment engagement. Therapists identify parents' lack of involvement as a key treatment barrier while parents report feeling excluded and unimportant by therapists. This information can be used to inform therapists that parents are interested in participating in their children's treatment. However, parents are sensitive to therapists' judgments and may need open acknowledgement of their struggles and efforts raising their child/ren. Open communication from the start of treatment regarding treatment goals and treatment strategies (i.e. parent training) may circumvent misunderstandings and make parents feel more a part of the solution.

Findings from this study reinforce the complex nature of real-world families. These children and their families have abundant needs that therapists and parents struggle to address and meet. Parents enthusiastically discussed their needs and stressors, including feeling overwhelmed by their children's diagnoses. Parents clearly want to be heard and validated.



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